AN URBAN INSTITUTE PAPER ON HEALTH

Modifying Medicaid Eligibility and Benefits

BRUCE SPITZ
JOHN HOLAHAN

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Preface

This paper is the first of a four-part series on alternative strategies for controlling the costs of state Medicaid programs. These papers were funded by the National Center for Health Services Research as part of a larger effort to analyze the effect the 1974-1975 recession had on the states' ability to finance health services for the poor. The Medicaid Cost Containment Series is a systematic examination of (1) state options which are permitted by federal regulations and (2) state options which would improve the efficiency and effectiveness of the program. These alternatives do not necessarily overlap. Indeed, federal regulations often preclude rational state behavior. We therefore set forth the cost containment issues and options regarding Medicaid eligibility, benefits, provider reimbursement and utilization controls. We then address possible changes in federal regulations and financing mechanisms which might improve state management of Medicaid.

The first chapter of this paper addresses states' choices with respect to placing limitations on eligibility. The chapter examines the eligibility requirements mandated by federal regulations and isolates choices available to the states. Our general conclusion is that programs are unlikely to find a resolution to Medicaid fiscal problems through either the manipulation of eligibility criteria or increased quality control efforts. The options are either politically unpalatable, insignificantly cost effective, too costly to implement or of such a long-run nature that they will not provide the immediate aid desired.

A reduction in the number of individuals eligible for Medicaid is a very desirable option for the states from a short-term financial perspective because of the high costs per eligible person. For the most part, cutbacks in eligibility have not proven attractive for the states because of the hardship imposed and because of the strong probability that the burden would merely be shifted onto another state program or to local governments. Individuals no longer eligible for the program may face a substantial financial burden in paying for care. It is perhaps more likely that needed care will not be sought. If care is foregone by children, society may bear significant costs in the future. If care is foregone by the aged and disabled, the result may be greater institutional costs in the future. Physicians may bear some of these costs on a charitable basis as they did before Medicaid or they may simply refuse to do so. The deficits of voluntary and municipal hospitals will in some cases be increased and in others costs of uncovered patients will be shifted onto other third-party payers or to the uninsured. Expenditures of local governments are likely to increase as deficits of local hospitals and other health facilities increase. Reductions in Medicaid eligibility may also increase costs for other state or federally-financed health programs such as Neighborhood Health Centers, Community Mental Health Clinics and Veterans Administration programs.

Reducing the number of ineligibles -- those appropriately determined to be eligible -- and the amount of client fraud has considerably more political appeal. Methods of controlling ineligibility and fraudulent use of services are not well developed at this time. Identification of ineligible persons and fraudulent users of services requires sophisticated data

processing systems and a high degree of coordination among the state agencies involved. The chapter concludes by observing that there is a point where the costs of additional monitoring exceeds the savings from successful discoveries. Unfortunately, this point is too frequently overlooked by critics of the Medicaid program.

The second chapter, Benefit Coverage, examines the choices states have in reducing program costs through limitations on its benefit package. The federal government requires that all Medicaid programs offer a basic benefit package consisting of "mandatory" services. In addition, there is a lengthy list of what are termed "optional" services which may be offered at the states' discretion. Elimination of or limitations on covered benefits has been the most frequently employed means used by states in an effort to contain the costs of their Medicaid programs. The paper analyzes the implications of limiting or eliminating each of several services in some detail. We argue that, in general, elimination of or limitations on benefits will not be a wise or effective cost containment strategy.

First, attempts to limit benefits are inherently inequitable because they apply to all eligible individuals regardless of medical status. Thus, those with the most severe disabilities are likely to suffer the greatest hardships when benefits are reduced. This raises questions about the efficiency and equity of benefit limitations. However, because there is no clear understanding of how medical services interact as essential complements to and substitutes for other services, it is not evident that the elimination of certain services will result in cost savings. In fact, it is plausible that

a state may ultimately increase expenditures because some optional services were eliminated. Similarly, Medicaid benefits often serve as less expensive substitutes for a comparable service funded entirely by the state or local government, e.g., care in mental hospitals and intermediate care facilities. Myopic concern with limiting Medicaid expenditures can lead to a greater state burden for those services. Also, because benefit limitations are subject to tight procedural requirements, failure to give adequate and detailed notice to provide hearings for recipients before cutbacks go into effect can cause a program to be enjoined from putting the limitations into effect.

CHAPTER I
ELIGIBILITY

A. Introduction

The Medicaid eligibility process is the mechanism which joins this country's largest health program to our major welfare programs.[1] Eligibility determination is a complex process. It is at times Byzantine, at times simpleminded, at times unreasonable. But it is always political. It defines who will receive Medicaid health services, but in doing so it places those eligibles in the context of indigency and poverty. Because of this admixture of politics, poverty, costly medical care and welfare, discussions of cost containment measures in the Medicaid program provoke consideration of reductions in the number of eligible families and individuals. The cost per recipient alone makes this an "attractive" option. In cash assistance categories, 1974 Medicaid outlays per user of services in selected states were as high as $1,532 for the aged, $510 for AFDC adults and $195 for AFDC children, as shown in Table I. Costs are typically higher for the medically needy. Indeed, in some instances, the medically needy consume four to five times the Medicaid resources than their cash assistance counterparts.

The enormous increases in Medicaid costs have not been due merely to the cost differential between the categorically and the medically needy. The major reason for Medicaid's rapidly expanding costs has been the increase in eligibles associated with the general expansion of federal-state welfare programs.[2] Yet, because of various political and administrative constraints, and, in some cases, because of a lack of economic incentives, few states have actually attempted to limit eligibility.

Table I
Expenditures per Recipient, All Services, 1974

States	Aged		AFDC-Adults		AFDC-Children	
	Categorically Needy*	Medically Needy*	Categorically Needy*	Medically Needy*	Categorically Needy*	Medically Needy*
California	$ 198.98	$1,660.75	$ 363.03	$ 414.22	$ 174.08	$ 213.12
Connecticut	1,532.27	3,211.48	506.17	563.02	173.94	203.72
Georgia	347.92	1,963.63	364.76	230.77	128.53	165.01
Maryland	744.03	1,128.38	439.87	372.11	175.09	203.62
Michigan	763.51	2,465.01	510.19	636.66	169.47	641.30
Mississippi	319.97	2,346.57	243.44	237.38	87.69	157.01
Montana	1,276.31	N/A	351.31	N/A	161.84	N/A
New Jersey	894.25	4,212.52	452.32	510.55	194.91	148.60
Ohio	1,475.37	245.17	382.12	324.28	156.01	146.53
Pennsylvania	887.95	1,191.57	176.82	245.20	87.50	165.46
Texas	576.64	2,101.32	421.65	266.94	148.18	233.28
Virginia	483.07	958.15	376.52	385.80	145.21	310.50
Washington	740.83	1,530.47	335.05	243.68	145.94	174.39
Wisconsin	569.97	2,050.98	475.04	475.46	169.13	545.27
U.S.	458.95	2,027.86	368.85	437.60	164.62	218.55

Source: Calculated from Tables 6, 7, 17 and 18, "Numbers of Recipients and Amounts of Payments under Medicaid, 1974" Social and Rehabilitation Service, USDHEW, Advance Copy.

* The terms categorically needy and medically needy are not technically correct. The categorically needy category includes expenditures for those who were receiving cash assistance payments. The medically needy category includes those who are eligible for cash assistance but refuse it, and those who are in institutions, such as homes for the disabled and aged. As a result, numbers will appear in the medically needy columns for states with no medically needy program.

Throughout this paper, we argue that program managers are unlikely to find a resolution of Medicaid fiscal problems through either the manipulation of eligibility criteria or increased quality control efforts. The options are either politically unpalatable, insignificantly cost effective, too costly to implement or of such a long-run nature that they will not provide the immediate aid desired.

Medicaid eligibility requirements are perhaps the most confusing aspect of the program. The states have certain mandatory coverage requirements. They must cover all Aid to Families with Dependent Children (AFDC) recipients and most adult groups receiving Supplemental Security Income (SSI). Beyond that, states face a confusing array of choices. Yet, because there are options, there are several ways of reducing Medicaid costs through eligibility limitations. This does not imply that these choices are socially advisable, but simply that they exist.

Several state administrators informed us that it was simply not desirable to eliminate entire groups from eligibility for critical services, despite the fiscal attractiveness. They typically indicated strong political opposition to reducing Medicaid eligibility. Clients pressed for continued coverage. Providers lobbied for continued payment of services for the indigent. Counties and localities argued against the inevitable increases in their tax burden which would follow as they assumed the medical costs for former Medicaid recipients. Eligibility cutbacks are often accompanied by legal challenges and complications, unsavory press and demonstrations. Finally, the administrative problems can be enormous: eligibility changes are often difficult to implement, and even the smallest

modifications can require a massive synchronization of state and county offices, clients and providers.

Reducing the number of ineligibles* and the amount of client fraud has considerably more political appeal. However, the means of detecting ineligible individuals and fraudulent use of services are not well developed at this time. Changes in procedures to identify ineligible persons and fraudulent users of services require sophisticated data processing systems and a high degree of coordination among the state agencies involved.

As a political goal, the elimination of all ineligible clients may be highly desirable. As an economic goal, it simply ignores the cost of monitoring. There is a point where the costs of additional monitoring exceed the savings from successful discoveries. In the AFDC program, for example, there is some evidence that the optimal error rate (the percentage of eligibles who are not in fact eligible) is greater than the 3 percent federal guideline. In a recent study, 45 states were found to have error rates in excess of 3 percent.[3] If the AFDC experience is an indication, we should expect the quality control efforts to be less successful in the more complex SSI and medically needy programs.

In short, states may reduce program cost in this area by restricting the eligibility criteria or increasing the monitoring of the eligibility process. Either choice poses enormous problems.

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*There are two groups of individuals classified as ineligible. The first consists of those who were inappropriately or erroneously granted Medicaid eligibility. The second consists of individuals whose initial eligibility determination correctly granted them coverage. Over time, these clients have experienced significant changes in their welfare status (such as changes in income, employment, marital status, etc.). If these changes would have resulted in loss of Medicaid coverage but were not reported by the client or acted upon by the case worker, then that individual becomes a part of the ineligible category.

B. Limitations on Eligibility Criteria

1. The Categorically Needy

All states which participate in Medicaid cover those eligible for cash assistance. These categories include Aid to Families with Dependent Children (AFDC) and recipients of Supplementary Security Income (SSI).[4] At a minimum, this latter group consists of recipients of the former categorical assistance program of aid to the aged, blind, and disabled.

In the states, eligibility is determined by complex means tests. These tests differ with each state. The primary determinant of eligibility is the standard of need calculated by each state, based on its assessment of the requirements of a family of a given size with no other source of income. Cash assistance payments are made on the basis of some portion of the need standard determined for the recipient unit. Monthly payments depend on the family's non-assistance income, less deductions. Some states use the full standard and pay the full budget deficit. Some, however, use a reduced standard and determine payments by comparing current resources to the reduced standard. Still others, using either the full or reduced standard, pay only a percentage of the budget deficit. In addition, some states place a maximum on the payment allowed.[5]

After disregarding a certain minimal level of income ($30 per month) and making an allowance for child care and other work-related expenses, a family's assistance payments are reduced by 67 cents for each dollar of earnings until payments equal zero at the "breakeven" point. The level of income a family can have and remain eligible for cash assistance and Medicaid will vary by state because the payment standard (the level of

cash assistance payments if earned income is zero) and the amount of child care and work-related expenses permitted vary widely among states.

Because of the additional criteria calculations and determinations made at the federal level for SSI recipients, it is conceptually more convenient to discuss the AFDC and SSI categories separately.

a. AFDC

In the case of families and children, the state program must include all persons receiving aid under the state's AFDC plan, and all persons under 21 who are dependent children under the state's AFDC plan. In addition, all families whose eligibility for AFDC was terminated because of increased income must be covered for four months following termination.*

Policymakers wishing to restrict the AFDC categorically needy population can do one of three things. They can lower the AFDC need standard, further limit their reduced standard or reduce the amounts of protected assets. Restriction of the need or reduced standard can be implemented by an overt reduction or (as was the case during recent inflationary periods) by failing to increase the standard. The latter measure reduces the standard in real terms. It may, in effect, affect the eligibility status of those whose income and resources are near the need standard. It will also raise basic political and ethical issues concerning the validity of reducing eligibility criteria during periods of increased unemployment and economic displacement.

A more subtle approach is to reduce the amount of protected assets and income disregards. With the Social Security Amendments of 1967, certain earned income is ignored ($30 plus 1/3 of the remainder each month)

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*Assuming they received AFDC payments for three of the six months preceding termination of eligibility.

in calculating AFDC payments, and certain work-related and child care expenses are deducted. As a result, once a family becomes eligible, its total income, including AFDC payments and earnings, can increase to levels substantially above the standard. Eligibility of these families with earned incomes can be affected by a ceiling on work-related or child care expenses, as well as by changes in either the effective standard, the need standard or the reduced standard used by the state. However, most AFDC recipient families have little or no earnings; as a result, the proportion of families affected by changes in any of these variables is likely to be small.[6] Nonetheless, several states have frozen need standards, with some inevitable, though probably small, effect on Medicaid.

Other AFDC cutbacks depend upon the extent to which the state has currently extended benefits to a group labeled the "optionally categorically needy." As the name indicates, coverage is supplied at the discretion of the state. This group consists of individuals who have the following characteristics:

(1) Persons who would be eligible for AFDC payments (or certain state supplementary payments) but who have not applied for cash assistance.[7]

(2) All persons under age 21 who meet the AFDC income and resource limits but who do not meet the definition of a dependent child under the AFDC program, such as emancipated children or children of two-parent homes where neither parent is absent, incapacitated or unemployed. States may limit coverage to reasonable groups such as children in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities.[8]

(3) Certain relatives who are caring for children under age 21 who would be eligible for AFDC payments except for AFDC age or school attendance requirements.[9]

(4) Persons who would be eligible for AFDC payments if they did not receive child care services through the agency but had to pay child care costs out of their earnings.[10]

(5) Persons who would be eligible for AFDC payments if the State AFDC program were as broad as the Social Security Act allows, such as persons who would be eligible for AFDC payments if the State AFDC program included unborn children of families with unemployed fathers.[11]

There is no information on how numerous these individuals are because they are aggregated with all AFDC eligibles in the national Medicaid statistics. Therefore, precise estimates of costs incurred by individuals in each of these groups is not possible. Nonetheless, costs are incurred, and one cost control option is to eliminate their coverage.

Elimination of the first group is a senseless proposition. This group consists of individuals who could receive cash payment but, for a variety of reasons (pride, family pressure, etc.), choose only to receive medical assistance. By eliminating this optional group, the state would force these individuals to apply for full benefits. As a result, Medicaid costs would be unaffected, and total welfare costs would increase.

The second option permits states to cover all children financially eligible and will affect children in families not categorically eligible for AFDC. Several states (17 as of May 1, 1973) have extended coverage to all children, and 39 states have chosen to extend coverage to children in foster care settings and other private child-caring institutions but not to all financially eligible children. Eliminating coverage of this group would also result in increased costs to the state to finance their medical care. It would also result in compromising humanitarian objectives and sacrificing an investment in the future lives of those children.

By extending coverage to a responsible relative (who might otherwise not be covered), the state provides an incentive for that individual to continue to act as a guardian, thereby eliminating the cost of institutionalizing the children or of engaging in a search process to find a foster home for them. Elimination of this group would, again, probably result in few savings. The fourth option also makes little sense in practice. If coverage is eliminated, all the individual need do is take her child out of the welfare agency's appointed child care center and put the child in one that she has found.

Perhaps the major choice facing the states here is whether to continue coverage of AFDC-UP families with unemployed fathers. Such families are covered in 26 states and can be a fairly substantial number of individuals in such states. In August 1975, AFDC-Unemployed Parent (UP) families accounted for the percentages of eligible persons found in Table II on the following page. Not only does the AFDC-UP group represent a significant portion of the AFDC population; there is also some indication that they are more costly than single-parent AFDC cases. For example, in Illinois, 10 percent of the AFDC-UP population had 11 or more physician or outpatient visits during fiscal 1975. In the regular AFDC population, only 7 percent had more than 10 visits.[12]

A recent Supreme Court decision, Philbrook v. Glodgett, allowed individuals to choose between unemployment insurance and AFDC payments, with the latter including Medicaid eligibility. Before that decision, individuals potentially eligible as unemployed fathers were required to exhaust any and all unemployment insurance before they became eligible for

Table II

AFDC-UP Recipients as a Percent of All AFDC Recipients

(August 1975)

State	AFDC-UP as % of AFDC
California	11.4
Illinois	9.3
Maryland	2.3
Michigan	8.6
New York	1.8
Ohio	13.2
Oregon	14.9
Pennsylvania	3.8
Utah	12.6
Washington	10.0

Source: Calculated from Table 4, "Aid to Families with Dependent Children," and Table 5, "Aid to Families with Dependent Children, Unemployed Father Segment," from Public Assistance Statistics, August 1975.

welfare benefits. The effect of the AFDC-UP option on AFDC caseloads will undoubtedly increase after the summer of 1975. As a result, states in severe financial straits may more seriously consider eliminating this group from AFDC coverage. In addition, states have the option of covering children in such families without providing coverage to parents.

However, there are several problems with eliminating AFDC-UP and any of the other optionally categorically needy. Cutbacks will either place the entire burden on the state, increase health care costs of local governments, or damage the state government politically because of the vulnerability of the individuals involved. Finally, eliminating numerically small groups of individuals may reduce Medicaid's medical costs somewhat but may be quite expensive from an administrative point of view. Not only

do program managers run into the expected distortions (as policy formed at the state level is transformed into action at the local level), but possible resistance by local workers, coupled with the fair hearings process, may create costly bottlenecks.

b. SSI

Prior to 1972, state control over the eligibility criteria for AFDC, the aged, the blind and the disabled was comparable. States determined income and resource levels for these groups and established their own definitions of blindness and disability. The 1972 amendments to the Social Security Act were an attempt to lessen the disparity between the states' needs standards, cash payments and disability definitions. Aid to the aged, blind and disabled was subsumed under one program of Supplemental Security Income. A nationwide minimum cash payment was established; a uniform definition of disability was applied; and federal administration of the program itself was made available to the states. However, since Medicaid was still a joint state/federal operation, the extension of Medicaid benefits was not automatically tied to national SSI eligibility determination. In fact, the states were allowed to choose one of three ways in which they might extend Medicaid coverage to SSI recipients by covering:

(1) all individuals receiving benefits under the SSI program (with eligibility criteria established by the federal government)

(2) all SSI recipients and all individuals receiving a state supplementary payment (i.e., coverage could be extended in those states where financial criteria were more liberal than those of the federal government)

(3) individuals meeting the eligibility criteria used for medical assistance on January 1, 1972. (This made allowances for states with financial criteria less generous than those of federal government.)[13]

These options were designed to minimize the impact that SSI programs might have in the states' Medicaid systems. In order to minimize the disruptive impact that the changeover might have on recipients, the states were required to continue coverage of the following groups eligible for Medicaid in December 1973:

(1) all individuals receiving a mandatory state supplementary payment, so that they would not receive less income under SSI than under the previous assistance plan

(2) all Medicaid eligibles who were "essential spouses" in December 1973

(3) all Medicaid eligibles in nursing homes in December 1973 who would have been eligible for welfare if they had not been in such institutions.[14]

The SSI eligibility options and the grandfathering in of December 1973 eligibles tend to complicate a complicated process. They not only impede eligibility determinations; they also obscure state choices about Medicaid coverage for SSI individuals. This is due, in part, to the addition of another layer of eligibility determination and, in part, to SSI's presumptive disability and a modified "spend-down." In terms of these latter devices, different requirements are placed upon states depending on whether they opted for eligibility criteria more restrictive than federal SSI standards* (so-called Section 209 states) or accepted the federal standard (this last group also includes states which have more liberal standards than those set by HEW). For example, "conditional eligibility" exists

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*Eligibility standards not lower than the state's January 1, 1972, criteria but not more than the federal SSI levels.

> when an SSI applicant may enter into an agreement with SSI to dispose of excess resources within a given time (usually 6 months); during this time he is granted "conditional eligibility" for SSI and receives payment. If he does not satisfy the terms of the agreement, all payments made are considered overpayments which are to be recovered by SSI.[15]

Section 209 states do not have to extend Medicaid coverage to individuals with conditional eligibility; all other states must do so.

Another instance exists with a determination of "presumptive disability." This process

> provides for up to 3 months SSI benefits to individuals who are determined to meet all other eligibility criteria, pending disability determination (including blindness). The Bureau of Supplementary Security Income indicates that such determinations will be limited to those who also can present prima facie evidence of disability and who qualify for an emergency advance payment or whose disability decision is inordinately delayed (i.e., beyond 60 days from application date.)[16]

Again, Section 209 states have the option of covering these individuals; all other states must do so.

Finally, the disincentive to opt for Section 209 status affects all those states without a medically needy program. Section 209 states must permit individuals to spend-down; all other states need not extend that coverage.[17] The spend-down permits individuals to become eligible for Medicaid when their total income, less SSI, state supplementary payments and incurred medical expenses, is less than the 1972 income eligibility standard. Thus, while appearing to be more restrictive than the alternatives, the third choice may potentially be more costly if substantial numbers of individuals use the spend-down mechanism. Yet, because the spend-down provision has always been difficult for Medicaid recipients, in

that it requires detailed information on income and on covered and uncovered medical expenses, the ultimate effect is unclear. States choosing either of the first two options do not have to provide for a spend-down, unless they also cover the medically needy. However, they are permitted but not required to provide long-term care services to individuals with incomes less than 300 percent of the SSI benefit level.[18]

This differential treatment does not permit states to manipulate their SSI needs standards as freely as their AFDC standard. Without estimates on the number of potential spend-down recipients, the decision for a state without a medically needy program to select 209 status may increase the state's Medicaid budget.

In terms of optional categorically related individuals, there are two classifications which affect SSI eligibility:

(1) individuals who meet all conditions of eligibility for benefits under AFDC, SSI or state supplementary benefits but applied only for medical assistance[19]

(2) individuals in a facility eligible for Medicaid reimbursement who, if they left such a facility, would be eligible for aid under AFDC, SSI or state supplementary payments.[20]

Both optional groups can be incorporated into the AFDC program as well. And, as noted previously, elimination of these groups would most likely increase costs.

As with AFDC, the first group consists of individuals who could receive cash assistance and Medicaid but who choose to receive Medicaid only. Elimination of the group would force these individuals onto the cash assistance program. Their Medicaid status would thus remain unaltered.

In the case of the second optional group, our discussion of the AFDC program related primarily to foster care and child-care settings. With SSI, the "facility" refers primarily to care in skilled nursing and intermediate care facilities; individuals involved are thus not, in reality, an optional group for the states. The option applies to states which provide benefits to SSI and/or state supplementary payment recipients and which do not have a medically needy program. These states are required to provide care only to those receiving SSI payments. As such, only those institutionalized individuals with incomes less than the personal needs allowance permitted by the state are mandatory eligibles. The states may cover all other long-term care patients with incomes up to 300 percent of the federal SSI payments, but this extended coverage is optional.

The regulation was established following the introduction of SSI. It relegates a substantial portion of the skilled nursing and intermediate care facility population in those states (those with no medically needy program and those choosing the restricted adult eligibility criteria) to the status of an optional categorically needy group. In practice, most of these states cover this group because, over time, particularly with the expansion of Medicaid, the nursing home industry and the dependence of the elderly population on that industry have grown tremendously. As such, eliminating this group would either greatly increase costs for the states or cause disruptions of considerable magnitude.

2. The Medically Needy

The categorically needy approach has several glaring inadequacies. The classification of need according to age, pre-existing disabilities or dependent children is and has been a political determination, a remnant of the "deserving poor" criteria that have developed throughout our history of welfare laws.[21] This classification does not assert that, when illness strikes an impoverished single adult male or a very low income couple in their late fifties, those individuals are in any less need of medical care or any less financially inhibited from receiving that care. The categorically needy classification system merely asserts that it is politically unfeasible to federally mandate an extension of eligibility. (Those individuals may be covered and paid for entirely by the state under the non-categorically related Medicaid option.) However, even within the realm of the elderly, the disabled and dependent children, the categorically needy approach is insufficient. It is insufficient because it fails to recognize the catastrophic impact that medical costs can have on the poor, the near poor and the middle class. For example, a seventy-year old man whose sole source of income is a $500 monthly retirement allowance will be impoverished by an extended stay in a nursing home. Yet, because of his pension, he will not qualify for the categorically needy program.

In order to accommodate individuals who (1) meet all criteria for categorically needy assistance with the exception of income and (2) have incurred relatively large medical bills, the federal government permits the states to extend coverage to these individuals under a medically needy program. As of 1969, the medically needy for all programs were limited to

those whose income did not exceed 133-1/3 percent of the maximum assistance payments for similarly sized families under AFDC.[22] That is, families whose monthly incomes are between the AFDC payment standard and 133-1/3 percent of that standard are eligible for assistance as medically needy. The states may use 133-1/3 percent of the AFDC payment standard as the maximum level of income. In the case of two-person families or individuals, the minimum medically needy income level is the higher of the AFDC payment standard, appropriately applied, or the highest level of payment generally available to SSI individuals. The last condition basically increases the level of income which is protected for individuals in the adult categories who become eligible under the spend-down provision. However, while income levels may be increased, a basic problem remains: the individual must nearly exhaust his savings and other resources before becoming eligible.

Through the spend-down provision, persons or families can also become eligible for medical assistance under the medically needy program if they have income above the 133-1/3 percent level (or lower, if the state chooses) but have high medical expenses which reduce income below the medically needy maximum. The spend-down permits Medicaid to pay all medical expenses which reduce income below the medically needy maximum. For example, if a program has a medically needy maximum (monthly) of $400, a family with income of $500 and medical expenses of $150 would have $50 paid by Medicaid. Clearly, families in states with medically needy programs could have quite large incomes and receive Medicaid payments under this catastrophic-protection provision.

There are three basic choices for reducing eligibility and expenditures under a medically needy program. First, a state with a medically needy progran can eliminate it. Second, it can reduce the protected income level to the permissible minimum. Third, it can extend the time span over which family or individual income is compared to the financial eligibility screens used for the medically needy.

The problem with eliminating the medically needy is that it is not feasible once the state has a medically needy program in place. Elderly Medicaid nursing home patients are the primary impediment. It is politically impossible to create an institutional level of dependency among an impoverished elderly population and then suddenly cease to provide that service. The effect on the patients would be dramatic. It would create coalitions of elderly citizens, nursing home providers, and fraternal and religious orders to prevent any such move. In the event that the state's governor and legislature could withstand that pressure, there is still the question as to whether any savings would be realized. Displaced Medicaid patients would have to find alternative living arrangements. Some, undoubtedly, would be placed in hospitals, others in county and city supported institutions and other adult foster care settings. A bulk of the burden for the support of these individuals would be shifted to lower levels of government which lack federal financial participation. Further, in most states, Medicaid is the principal purchaser of long-term care services. A large portion of those expenditures are made on behalf of the medically needy. If the program were eliminated, the nursing home industry would be critically affected. The political and economic repercussions

that would follow the flow of these developments could cause extreme discomfort for the state legislature.

The second option in controlling costs of a medically needy program is to reduce the level of protected income and resources. Federal law permits states to establish the medically needy income screen below 133 percent of the AFDC standard. A reduction of the protected income level might not generate significant savings. In fact, if it complicates the administration of the program (by requiring that all medically needy individuals' records be reviewed and adjusted), it may cost more to implement than could be realized in program savings for two reasons. First, the most costly portion of the medically needy population are in long-term care facilities.[23] All of their income (minus small personal needs allowance) goes toward paying their medical expenses. Their eligibility is a function of the difference between their nursing home costs and their income. Since nursing homes generally charge more in a month than 133 percent of the AFDC standard, a reduction in the standard will not affect this group. Savings that might be generated by the non-institutionalized medically needy are a function of the number of eligibles whose income exceeds the AFDC standard. Indications from Massachusetts and North Carolina are that that population is very small. For example, in 1974, only 2 percent of Massachusetts' non-institutionalized Medicaid population and 6 percent of North Carolina's population actually had to spend-down. All the rest were either categorically needy or medically needy whose income was at or less than the medically needy income screen.[24]

The third option is to increase the length of time used to compare income against financial eligibility standards. Low income individuals have major fluctuations in income. Some individuals or families who have little or no income at a particular time can have far more adequate incomes over a six-month period. If a medically needy program compares income and medical expenses for a given month against a medically needy income screen established on a monthly basis, its expenditures are likely to be significantly larger than if six months' income and medical expenses are compared with a six-month medically needy income screen. For example, assume a family has an income of $400 per month for each of six months. The state in which they reside has a medically needy income standard of $300. The family incurs medical expenses of $300 in the first month and $50 in each of the other five months. If a one-month test is used, the family would be eligible for $200 of Medicaid payments in the month during which it incurred $300 of medical care expenses. If a six-month medically needy standard of $1800 were used, the family would receive no Medicaid payments because its income was $2400 and its medical expenses only $550. Expanding the length of time for the comparison of income against financial eligibility screens will primarily affect individuals or families with fluctuations in earned income and/or acute care expenses. It will reduce administrative costs. Further, it should not have major effects on long-term care expenditures, the bulk of outlays in medically needy programs.[25]

3. The Non-Categorically Medically Needy

Finally, there are groups of individuals which states may cover entirely at their own expense. Technically referred to as the non-categorically medically needy, they are more commonly called "general

assistance" eligibles. These groups include individuals such as those who are receiving or are eligible for general assistance under a statewide program; those between the ages of 21 and 65 who have enough income and resources for daily needs but not for medical expenses and who are not eligible for Medicaid under the adult or AFDC categories; and those with income above the federally established maximum for the medically needy.[26] Relatively few states (e.g., Maryland, California and New York) cover such individuals. Massachusetts eliminated its program of medical assistance to these groups in November 1975 because of its fiscal crisis. There is an obvious fiscal incentive to eliminate these individuals, since the state bears 100 percent of the cost. These individuals tend to be highly unpopular politically, as reflected from their omission from coverage in all federal welfare programs, thus augmenting the attractiveness of limiting their eligibility. Nonetheless, these groups may include many people who, despite lack of skills, are employable at low wages. The state could be vulnerable to charges that the non-working welfare recipient receives better treatment than the working poor. Such charges would be, and are, grounded in the general assistance experience. In Massachusetts, for example, a survey conducted four months after the termination of the state's general assistance program revealed that:

- 28% had been receiving some form of medical treatment at the point of cutoff in November 1975. Of this group, 61% reported they stopped treatment completely <u>because of the cutoff</u>, while 27% continued in care and 7% continued to receive care by changing doctors or hospitals.

- 29% reported a medical emergency during the 4-month period. Of this group, 8% did not seek care, 20% sought care and were denied, and 72% received care.

- Of those who received care, approximately 26% paid for it out of their own funds or with the help of friends or relatives, 17% received care under Medicaid because they were under 21, and approximately 54% received free care.

- In response to a direct question about the "impact" of the elimination of medical assistance, 41% reported no impact or minor impact (this includes 12% still eligible for medical assistance because they are under 21), while 42% reported a "major impact." 17% of the respondents did not provide a usable answer to the question.

- In response to specific problem questions:

  31% reported "I cannot get medical care I need."
  22% reported "I cannot get drugs and prescriptions that I need."
  39% reported "I cannot make visits to doctor/dentist, etc."[27]

Undoubtedly, the cutoff created medical hardships for some of the former clients. However, as noted by the shifting to the Medicaid program (as a categorically needy child) or to sources of free care (municipal hospitals or providers assuming the cost of the service), the elimination of general assistance does not eliminate the clients or their medical needs. In Massachusetts, it appears that, in a majority of instances, the client assumed the burden of not receiving care. Over the long run, if medical conditions deteriorate and individuals are forced to increase their reliance on the free care of municipal institutions, then the state has merely shifted a proportion of its general assistance costs to the more regressive local tax system of the counties and localities.

The questions raised in the elimination of general assistance can be applied to all considerations of eligibility. If cost containment is the primary thrust, then the main issue is that of alternative sources of medical care funding for previously eligible individuals. Does the former eligible individual pay for care or is care foregone? If care is foregone by children, what future costs will society bear? If care is foregone by the aged and disabled, will future institutional costs be greater than otherwise? Will physicians bear some of these costs on a charitable basis as they did before Medicaid? Will deficits of voluntary and municipal hospitals be increased, or can they be shifted to other third party payers or to the uninsured? Will expenditures of local governments increase as the deficits of local hospitals and other health facilities increase? Finally, will reductions in Medicaid eligibility increase costs for any other state-financed health programs?

C. Implication of Eligibility Cutbacks

Restriction of eligibility criteria suffers from four basic shortcomings. First, the elimination of optional groups under the categorically needy classification would result in either extremely marginal savings or increased state expenditures.

Second, while states could eliminate the medically needy classification, the political power and influence of the nursing home industry and the elderly, and the public reaction to "putting the aged out in the streets," make the option extremely unattractive.

Third, the eligibility regulations and procedures are so complex that it is difficult to predict the impact that either substantive or marginal changes will have on the eligible population. We do not know what the compensatory responses by eligibility determination workers or clients will be or how those responses will affect the system. We do know that very complex regulations are uniformly unenforceable and uniformly difficult to implement. These conditions have a tendency to increase the discretionary power of the social worker. We also know that, as organizations increase in size and complexity, changes in procedures are more difficult to carry out. In the short run, both of these factors -- the discretionary power of the social worker and the size and complexity of state welfare departments -- would act to severely distort changes in eligibility criteria. Since it is in the short run that the state needs assistance, this route may prove to be a futile attempt at cost containment.

Finally, substantive restrictions in eligibility criteria which coincide with recessionary periods are contradictory to the social and political function of welfare, i.e., the extension of aid to those in need and the stabilization of the community during periods of increased unemployment. Reducing the rolls through manipulation of eligibility criteria may be politically untenable.

D. Monitoring the Eligibility Process

1. Ineligibility and Client Fraud

Reducing the number of ineligibles -- those inappropriately determined to be eligible -- and the amount of client fraud -- the use of Medicaid services by individuals knowingly ineligible -- has considerably more

political appeal than eligibility cutbacks. Under the guise of a quality control program, the reduction of ineligibles is viewed not as a punitive measure but rather as one which insures that the truly needy have sufficient funds available for their use. The theme that "those in need will be unaffected by quality control" is a preamble to most political discussions of quality control efforts. Additionally, ineligiblity also seems to connote willful fraud. A concerted effort to rid the rolls of "welfare cheats" continually meets with broad approval at the state level. The acceptability of quality control is further enhanced by federal figures which estimate ineligibility at 9.3 percent of all AFDC categorical cases, 7.7 percent of the SSI categorically needy, and 20 percent of the medically needy.[28] Ineligibility among the medically needy alone is estimated to be as high as $600 million.[29] Finally, the term "quality control" evokes images of professional management, private sector efficiency and sound business administration. While still difficult to implement, it is considerably less repugnant to program managers than the constriction of eligibility criteria. (Interestingly enough, the term "quality control" emerges only in the discussion of ineligible clients or incorrect welfare payments. The term is not applied to other quality control areas in the Medicaid program; e.g., unnecessary surgery is monitored through "utilization review mechanisms," and fiscal behavior of the third party carrier is checked by means of "management and administrative reporting systems.")

However, for all its political attractiveness and image appeal, the quality control issue is an administrative problem. (Ironically, it is a problem created by the political grafting of a health care system to a welfare system.) Therefore, before attempting to evaluate the pros and cons of different monitoring mechanisms or the wisdom of different eligibility or fraud tolerance levels, we must examine what is involved when an individual seeks assistance. Because the vast majority of Medicaid recipients qualify as either categorically needy or medically needy, we shall restrict our attention to those two programs.

2. Categorically Needy Eligibility Determination

At this level, Medicaid and income maintenance programs completely overlap. The administrative agent, the eligibility determination worker, acts as the interface between welfare services and the client. Though eligibility workers may vary from state to state, within a state they share certain characteristics. They are among the lowest paid professionals in the system, well removed from the policy making process and yet empowered with broad discretionary authority regarding their clients. They are also asked to administer a program that they did not and would not design. It is a program so inherently complex that it could not have been constructed by individuals aware of the intake, processing and monitoring functions performed by caseworkers.

Bill Benton, former Assistant Director of Maryland's Department of Human Resources, has provided a graphic glimpse of what a caseworker must do before an individual is deemed eligible.

The eligibility determination process works in the following way: A prospective recipient must complete and sign an application for public assistance. In so doing an applicant must respond to 100 or more inquiries, the answers to each of which may affect the applicant's eligibility or the correct amount of the assistance payment. In addition, an applicant is commonly required to satisfy various other requirements, such as registering for the WIN program (a federally-established work training program), registering at the State Employment Services, providing information concerning an absent parent and/or the amount of child support payments, if any, etc. Many of the factors called for in the application process involve interpretations or judgments by the eligibility worker. For example, the eligibility worker must decide which of the applicant's expenses are 'work related', what portion of the applicant's rent is properly allocated to the assistance unit, what portions of the applicant's income are 'regular' income, how child support or other benefit payments should be allocated among various children, etc.

In addition, the eligibility worker must, on the basis of the information supplied, make numerous calculations in determining eligibility and the correct amount of the assistance payment. Basically, the level of assistance is a function of an applicant's need and resources compared against an existing state standard. The usual first step is the determination of the applicant's income. This must take into account the value of in-kind income as well as income in cash form. The latter must be broken down between earned income, support payments, other benefits and unearned income because each of these categories is treated differently in determining eligibility or the amount of payment.

Once income is determined it must be divided into regular and irregular income. Those figures must then each be converted to a monthly figure. As a general rule, applicants do not have a steady fixed monthly income; they may be reimbursed on a daily basis, they may work at irregular intervals, etc. Accordingly, the conversion to a monthly rate is itself a complicated arithmetic process. Once this conversion is made, the eligibility worker must determine what portions of that income are non-countable under federal regulations. (Examples of non-countable income are scholarships, income from certain work training programs, income earned under the Older Americans Act, etc.) Often some portion of the monthly income figure is exempt and some portion not exempt. As to that portion of an applicant's income that is not exempt, the eligibility worker must then make computations as required under income disregard regulations.

Perhaps the most difficult of all the calculations the eligibility worker is required to make involve income disregards. For example, certain types of income are subject to a flat $5 per month

disregard. Even this basic disregard, however, is subject to exception; and amendments to Title IV establish a new formula to be used in lieu of the flat $5 disregard in areas of child support. This, however, will be true for one year only. A different amount of Social Security benefits is disregarded under federal regulations. Likewise in computing the amount of an applicant's resources to determine if her assets are in excess of the maximum allowable, some assets are disregarded entirely. Certain portions of the value of some liquid assets are disregarded under the regulations; other portions of the value of fixed assets are disregarded. However, the amount of value to be disregarded will vary, depending upon the use to which the asset is put. For example, a client's automobile is excluded altogether as a resource if it is used to obtain or retain employment; if, however, the automobile is not used in connection with employment, only a portion of its value is disregarded.

The most complicated of all the disregard calculations arise under the earned income disregard regulations. Whether this disregard applies at all is not easy to know. It depends on whether an initial determination or a payment recomputation is involved, on the level of earned income of the applicant and others within her assistance unit in each of the preceding four months, and on whether there has been a recent change in employment status or earnings and why. Where this disregard is determined to be applicable the first step is to compute a monthly earned income figure for each person in the assistance unit. This is not easy in those cases where income includes payments under various federal work training or job development programs for some of these payments are counted and some are not. Once the monthly earned income is arrived at, expenses determined to be 'work related' are subtracted. These deductions are the monthly amount spent for such items as baby-sitting, transportation, Social Security deductions, union dues, retirement contributions, state and federal taxes, lunches, etc. These expenses, which can fluctuate, sometimes on a daily basis, must be tabulated on a monthly basis. The calculations must be not simply for the head of the house-hold but for each member of the assistance unit with earned income. This includes a child who earns money baby-sitting or a child who has a paper route.

In addition to income computations, determinations and calculations of the level of need of the applicant must be made. Some states, such as Maryland, have simplified these computations by the adoption of what is known as a 'flat grant' or consolidated standard of need. Under Maryland's 'flat grant' system the only variable is the size of the assistance unit. Some states' 'flat grants' include shelter as a variable, and other states have as many as a dozen variables under a 'flat grant'. However, flat grants are typically more expensive than individual need determinations because states

tend to set the flat grant figures high enough to avoid reducing benefits to most of the recipients under the previous individual determination system.

Federal regulations do not require flat grants and many states continue to operate under itemized need grants. These require taking into account a large number of factors which affect an assistance unit's level of need, such as rent, living arrangements, insurance, utilities, fuel, clothing, special diets, enrollment in school, etc. These computations can be quite complicated and usually vary from month to month. For example, calculating shelter allowance and utility costs would involve arriving at a monthly rental (many clients pay by the week), proration in instances where shelter is shared, averaging fluctuating utility expenses, determining whether a telephone is 'essential', applying a special allowance for a family that lives in public housing, and ascertaining whether rental payments, including internal rental arrangements among members of the family unit, were in fact paid in the amount stated.

The determination and calculation process described above must be made in the case of each applicant for assistance.[30]

After an individual has passed through this initial phase, federal regulations require a redetermination of his eligibility and level of payment at least every six months. Prior to the May 1976 court injunction prohibiting the application of federal quality control sanctions, HEW patched on a Catch-22 refrain to the six-month redetermination requirement; that is, although redeterminations were required only every six months, states were penalized if they failed to determine a change in a client's circumstance by the end of the second month following that change.[31]

3. Medically Needy Eligibility Determination

The major complication in this instance is the spend-down provision which requires that the eligibility worker review all the patient's medical bills, separating those which are covered by any other third party carrier, those which represent services not provided by Medicaid and those which are covered by Medicaid. The latter group represents the spend-down

liability which is applied to the individual's income and resources. It should be noted that spend-down liabilities have only to be incurred. It is unclear whether the prospective client has to pay for the services.[32]

From the caseworker's perspective, the spend-down is perhaps the most difficult administrative task. A 1975 SRS report on the spend-down process in five states (Maryland, Massachusetts, Michigan, North Carolina and Utah) observed:

> Spend-down applications mean extra work for the caseworker. The spend-down amount must be calculated, and the process of spending down must be explained to the applicant. This latter task is said by workers to be the most time-consuming aspect of handling a spend-down case since there are so many contingencies and technicalities involved such as incurment versus payment, what expenses are allowable, the relationship of third-party insurance, etc.
>
> A major problem in spend-down eligibility determination involves the determination of allowable expenses for meeting the spend-down. Determining the legitimacy of the medical expenses used in spending down is an area left almost entirely to caseworker discretion. It is not surprising, therefore, that most local offices visited defined the medical expenses allowed for meeting the spend-down differently. Only one state has produced an exact list of allowable expenses which should be counted in the spend-down. As a result, what expenses are allowable for spending down can vary considerably.
>
> Although spend-down is acknowledged by all states to be a difficult area of Medicaid eligibility, few adequate explanatory materials exist for workers, providers or applicants. Consequently, a second major problem involving spend-down and eligibility determination is that although spend-down is a more complicated and less familiar approach to Medicaid eligibility, inadequate guidance is available to those who are involved with it. As a result, confusion and frustration occur more frequently than with other Medicaid cases.[33]

Once we add to this (1) the requirement that medical expenses can be applied over a six-month period (i.e., against a six-month income stream), (2) the existence of a medically needy specific level of protected income,

and (3) the normal computations which the eligibility determination worker ordinarily makes, the picture of the determination procedures is fairly well exhausted.

From the perspective of claims processing, numerous problems arise. Were the bills incurred or paid for by the patient? Have the invoices been properly assigned to other third parties, the client and the program? Is the lag between the date of service and the date the bill is submitted critical (i.e., does it affect eligibility status)? And so on.[34]

The most interesting thing about the spend-down is the lesson we have not learned. Advocates of an income-related catastrophic national health insurance program wish away many of the problems by suggesting that the IRS should make the eligibility determination. Sidestepping the issue of the propriety of the IRS serving that function, questions still remain as to the treatment of individuals who do not submit returns, unearned and non-taxable income, fixed assets, covered and non-covered medical services, incurred medical bills and paid bills, etc. If these issues are not squarely addressed, it is likely that national catastrophic health insurance will be truly catastrophic.

4. Corrective Measures

Given this procedural situation, there are two types of actions which will result in ineligible cases: administrative errors and client errors. Administrative errors arise because policy and procedures were incorrectly applied, indicated actions were not taken (e.g., client-reported income was ignored), computational errors were made by the caseworker, or because of data system inadequacies. Client errors, of course, revolve around the information offered (or withheld) by individual clients. A series of

ameliorative measures are being applied or developed by the states. For example, corrective measures which can be employed to correct administrative problems include:

(1) Decreasing the caseload per worker. This measure would entail hiring more caseworkers and eligibility determination workers but it would enable those caseworkers to increase their monitoring of both new and established cases.

(2) Holding caseworker seminars and training sessions designed to correct administrative errors discovered through the sampling of records.

(3) Simplifying forms and procedures, e.g., using a standard form for multiple benefits.

(4) Increasing the selectivity of the process by focusing on subgroups with high error rate potentials. For example, institutionalized eighty-year-old males receiving aid over two years are less likely to experience a change in their welfare status than twenty-year-old women receiving aid for less than six months. The recertification process should therefore be geared to the likelihood that individuals within subgroups are ineligible.[35]

Reductions in client errors might be effected through:

(1) Initial and continued monitoring of client income, e.g., cross-checking of welfare rolls with state/city payrolls or state income tax returns.

(2) Initial and continued monitoring of client needs, e.g., performing unannounced home visits or verifying that AFDC recipients' children are enrolled in school.

(3) Provider verification of client identification, e.g., issuing Medicaid cards with client's picture or requiring identification in addition to the Medicaid card.

(4) Fraud deterrents, e.g., requiring face-to-face certification or personal pick-up of checks at the welfare office.[36]

The relative effectiveness and cost of all these measures are not well understood at present. However, some observations can be made. First, not all changes will yield comparable savings. While this observation may seem obvious, it implies that managers must be selective in their application of monitoring mechanisms. A wholesale commitment to "do everything we possibly can to eliminate ineligibility and fraud" will not be as effective as a more limited but more carefully designed strategy. Secondly, simplification of either policy or procedures is more likely to cause the desired changes than the addition of more complicated corrective measures. Finally, structural changes (i.e., modifications in policy) should precede managerial changes (i.e., attempts to improve the administration of existing policy). Again, while this observation may seem self-evident, the approach is ignored when monitoring strategies call for changes on all fronts or when ad hoc managerial changes are ordered while policy modifications are in progress. In the latter instance, the time lag between the time at which ad hoc measures are ordered and the time at which they are implemented is critical. It is possible that policy might change and that new managerial procedures might be ordered before the ad hoc changes had been assimilated by the organization. All of this would act to increase confusion, disruption and, quite possibly, ineligibility.

Any corrective action will, of course, be confronted with the same implementation problems encountered in most complex departments where lower level administrators are granted broad discretionary powers.

That does not mean that desired changes have not taken place, but only that they are occurring slowly. For example, under the prodding of a federal penalty for the AFDC categorically needy program, there was a decline in the number of ineligibles but it fell well short of the federal targets. (The AFDC goal is 3 percent or less. The national average in 1974 was 9.3 percent or less. The national average in 1974 was 9.3 percent with only four states--Arkansas, Mississippi, Oklahoma and Rhode Island--meeting the target.)[37]

The process is further complicated by the three separate quality control programs which have developed over time: one for the AFDC categorically needy, one for the SSI categorically needy, and one for the medical assistance-only (MA-only) eligibles. Each of these programs is directed by separate federal bureaus. Current emphasis is on the AFDC quality control program. The SSI program has encountered enormous eligibility difficulties--in part precipitated by federal eligibility determinations--and has only recently been subject to an organized and concerted effort to rectify the situation. The MA-only quality control program has just recently been implemented. Preliminary findings by the responsible agency on the extent of the MA-only ineligibility problem are still being examined and have not been released. From the perspective of a state's Medicaid program, the emphasis is somewhat perverse. In terms of enrolled eligibles, AFDC accounts for 58.7 percent of the Medicaid population, SSI 20.5 percent, and the MA-only 20.8 percent.[38] However, in terms of total Medicaid expenditures, AFDC accounts for 28.4 percent, SSI 28.9 percent and MA-only 42.7 percent.[39] Given their relative number and expenditure patterns, a state would have to disenroll more than forty ineligible AFDC clients before they could reap the Medicaid savings accrued from disenrolling one ineligible MA-only client.

The existence of three separate quality control programs, however, does provide some indication as to the rate at which the programs can be implemented and the reasonable level of ineligible participation in Medicaid. The first quality control effort was directed at the AFDC population in 1964 with a management control system designed around caseworker determination.[40] In 1970, Congressional investigations and expectant passage of the Family Assistance Plan prompted DHEW to pursue quality control more vigorously. Regulations were revised, data collection requirements were expanded, and target tolerance levels established. Two years later, 19 states had not fully implemented the basic 1964 system, let alone the more complex 1970 one.[41] In 1973, DHEW issued a directive that funds would be disallowed for incorrect assistance payments based upon quality control error rates. The 1973 regulations prompted more "cooperation" and a series of legal suits by the states. To the extent that data is reliable, there are indications that AFDC ineligible rates have dropped from 10.2 percent in 1973 to 7.5 percent in 1975.[42] There are also indications that these figures represent as low a rate as can reasonably be expected.

If we use the private sector as a gauge, we find that the commercial insurance industry experiences a 5 percent ineligibility rate (e.g., benefits received by individuals whose policies had lapsed).[43] It should be noted that, since the insurance industry does not generally administer complex means tests to their clients, that source of error has been eliminated and, thus, their ineligibility rate represents a very low estimate vis-a-vis Medicaid.

The experience of similar public programs is suggestive. For example, the quality control effort administered by the federal government for the SSI categorically needy population has experienced an increase in that ineligible population from 6.1 percent in 1974 to 7.7 percent in 1975.[44] It may well be that the complexity of the system is such that the reductions in ineligibility beyond the 7 percent level would be both unreasonable and extremely costly.*

In part, what is at issue is the way tolerance levels are set. As the oldest, most sophisticated and most comprehensive quality control effort, the AFDC program has served as a model for SSI and MA-only quality control, including the adoption of the AFDC three percent ineligibility and 5 percent overpayment tolerance levels as desirable and attainable goals.[46] Unfortunately, these levels were capriciously, almost whimsically, set by DHEW, as the U.S. District Court noted when it enjoined the federal government from

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*Upon reviewing the AFDC quality control situation as presented to the House Subcommittee on Oversight, Representative Vanik noted:

> "Certainly, the inability of most States to significantly reduce their error rates raises questions about the effectiveness of States' corrective actions, HEW's guidance and assistance in quality control, and the feasibility of the established tolerance levels.
>
> "I would like to point out that this subcommittee has had two hearings on problems in Social Security's supplemental security income program. This program has been plagued by error rates of up to 24 percent or even 29 percent, with the result that some $460 million in erroneous payments have been identified.
>
> "As a result of these Social Security errors, the supplements paid by the States have been in error. The States are contending that the Federal Government has caused them to make about $200 million in erroneous payments and the States are withholding that amount from Social Security. Social Security does not think that is proper. Yet here we have another arm of HEW--the Social and Rehabilitation Service--doing the exact same thing to the States. HEW and OMB should decide what they want. What is good for the goose should be good for the gander."[45]

withholding funds from states which exceeded these error rates.

> The initial establishment of tolerance levels at 3 percent and 5 percent was done so arbitrarily with no previous empirical study...these levels were set because the Secretary (of DHEW) felt they were attainable and were ones which the public would accept.[47]

The structure of the eligibility regulations and process also contributes to the problem. The regulations are so complex, and the administrative tasks so involved, that in order to meet the quality control goals set by the federal government, states would have to greatly increase the number of eligibility determination workers. Alternatively, they would need to have existing caseworkers concentrate a disproportionate amount of time on the eligibility process. They could also manipulate definitions, forms and books to give the appearance that error rates have declined. The first option is expensive, the second is an impediment to the main function of the social workers (e.g., helping clients), and the third constitutes a pro forma response which fails to change anything but federal disapproval. From the state's perspective, the last approach is the most desirable. It is faster and cheaper to implement, less disruptive, and equally effective in the appeasement of federal monitors. For example, the GAO performed a detailed audit of the experience of seven state AFDC quality control programs* for selected quarters between April 1973 and December 1974. The most common corrective actions employed by the states involved regulation revisions, staff training, increased client contact and reporting, and increased verification of income. The GAO found that:

> Of all these corrective actions, regulation revisions were particularly effective in reducing errors. Some states recognized that errors occurred because of difficulties in

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*The seven states were New York, California, Maryland, Colorado, Missouri, Nebraska and North Dakota.

> applying overly restrictive or complicated regulations. The states took action to eliminate such errors by liberalizing certain of their requirements and developing standards that are easier to administer. The revisions which liberalized program requirements were particularly effective in reducing such errors because, in effect, they redefined what constituted an error. For example, Colorado's regulations required that a family's allowance for shelter and utilities be based on actual costs. This provision was the cause of many errors as the eligibility technicians made computational errors. The state revised its regulations to minimize the potential for error by providing for a standard allowance. The revised regulation provided for basing a family's shelter and utilities allowance on the number of persons on assistance rather than on costs incurred. This regulation change was primarily responsible for the improvement in the state's aggregate error rate (including underpayments) from 26.8 percent in September 1972 to 22.4 percent in December 1974.
>
> As of June 1975, 18 states had revised their regulations to provide for some form of standard allowance for such items as shelter, utilities, and other items of need.... The other types of corrective actions had less impact in reducing error for one reason or another.[48]

The complexity of the system at the local and state level is compounded by mismanagement at the federal level. Without the rapid responsive issuance of federal policy and procedural guidelines, the eligibility process can become a skein of non-enforceable, non-implementable regulations. If the federal government cannot provide the states with clarification of federal eligibility regulations, then HEW's posture as a monitor of the eligibility process is severely compromised. Yet, by the Medical Service Administration's (MSA) own admission:

> A major problem is the inability of MSA to provide definitive policy guidance in response to state requests. This is due to the SRS policy clearance system which requires the clearance of any MSA-proposed policy by both the Office of Policy Control and the Office of General Counsel, and a number of other offices in the Office of the Administrator (e.g., the Associate Administrator for Management). Because each office may make revisions to the proposed policy, and there is no time period within which a given office must clear a document, it is not unusual for even a simple policy inquiry to

> require a year or more to receive clearance and be issued. Needless to say, such timing is useless for state agency staff who need decisions on a rapid turnaround basis because of the great impact such decisions have on the lives of recipients and on state budgets.[49]

Finally, monitoring is not a free good. As the more egregious cases are purged from the rolls, it becomes more and more expensive to discover ineligible clients. Under textbook conditions, quality control should stop at the point at which the cost of additional monitoring exceeds the savings from successful discoveries. Under public conditions, the political pressure to find the last "welfare cheat" often tends to obscure how costly the process is. HEW is not immune from this political preoccupation with cleansing the system of fraud. Indeed, HEW is often placed in a situation of justifying the quality control effort with extravagant claims of expected benefits. For example, in April 1974, HEW officials informed Congress:

> that while a cost-benefit analysis of the AFDC quality control program had not been made, the benefits were considered to be about 15 times greater than cost.[50]

Six months later HEW reported AFDC quality control savings of $71 million during the first six months of 1974, with a projected $62 million in savings for the second half of 1974.[51] The General Accounting Office (GAO) felt that these figures might have overstated the actual savings. A special study by the GAO found that, when program experience was limited to states which had statistically significant changes and when both <u>increases</u> and decreases in those states' error rates were tabulated, the savings attributed to AFDC quality control effort dropped to $26 million for the first six months of 1974, and to $42 million for the remainder of

1974.[52] The GAO also found that certain error rate reductions may not reduce welfare cost. In fact, in some instances the corrective measures which reduce error rates may increase costs.*

There were two glaring inadequacies of both the HEW and GAO 1974 AFDC savings estimates. Neither estimate included increased payments due to the discovery of underpayment errors, and neither included administrative costs.[54] Either might have been sufficient to offset whatever savings were generated. The administrative costs in particular have exhibited rapid increases in the past few years. Between 1972 and 1975, the annual cost of administering the AFDC program increased from $448 million to $1.1 billion.[55] During that period, the approximate dollar value of expenditures due to ineligibles and overpayment to AFDC recipients remained stable at $1 billion per year.[56] It is difficult to estimate what portion of that increase is due to quality control. However, it would be equally difficult to deny that a relationship exists. In 1973, AFDC error costs were approximately two and one-half times administrative costs. By the end of 1975, administrative costs exceeded error costs for the first time in the history of the program.[57]

The quest for the last welfare cheats often obscures the fact that there are welfare cheats who do not know they are welfare cheats because neither they nor their caseworkers are able to understand the eligibility criteria.**

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*Increased compliance with the requirement that non-exempted AFDC recipients register for work incentive training would reduce the error rate but would not reduce costs. Setting the grant level for cases is also a problem area. Frequent errors occur when basic budgetary allowances are determined for each client. If specific needs such as shelter and utility costs were included under one standard allowance, the error rate may decline. However, because the new standard allowance would attempt to minimize hardships, it could lead to increased costs.[53]

**Commenting on some of the negative side effects of the federal quality control effort, the Michigan Director of Social Services found that, "HEW's interpretation and publicity concerning quality control findings lead to

From a cost/benefit perspective, a purging and simplification of the process would be more effective than a purging of all ineligibles. States respond to existing incentives by changing the description of the process while avoiding substantive changes in the determination process itself. While this strategy may cut down monitoring costs, it fails to address the structural and institutional problems which generate an inordinate proportion of ineligibles.

E. Conclusions

Our discussion has focused on the eligibility options and problems confronting an individual state Medicaid program. Repeatedly, an analysis of the choices indicates that, in the short run, the use of the eligibility process as a cost containment mechanism is inadvisable. In the long run, changes are not only advisable; they are essential. More is at issue than the bizarre idiosyncracies of each state's Medicaid eligibility process or the inequities that exist within a given program. Each state may require an individual to undergo a series of different and complex eligibility determinations for each of a multitude of social service and welfare programs. An impoverished individual may be eligible for six or seven programs and ineligible for another dozen. From state to state, individuals with identical characteristics may be treated differently. In an attempt to be equitable and discerning, we have created a system the complexities of which engender arbitrary and inequitable treatment of the poor.

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increasing public mistrust in the public welfare system, and an increasing loss of confidence in the capacity of government to administer the system. National publicity of Michigan's error rate--eight percent ineligibility as a rule--has led to an impression that eight percent of the AFDC recipients are liars, cheats, and frauds. Such simply is not the case and those who publicize the figures know it is not the case. Or at least they should know."[58]

While a welfare reform package is well beyond the scope of this study, we would note that even this cursory review of the Medicaid program suggests the necessity of uniform nationwide eligibility criteria and procedures. The existence of one common approach would eliminate interstate inequities. It would allow the federal government to focus efforts on one program rather than fifty. States could share experiences and administrative improvements more easily. Federal and state monitoring would be facilitated. The use and misuse of eligibility standards as a cost containment mechanism would be curtailed.

Uniformity in the Medicaid program would also be an important step toward a uniform approach to all welfare programs. The administrative quagmire created by a multitude of welfare programs having slightly different eligibility processes increases the likelihood of an applicant being denied help. Eligibility workers are often unaware of all programs, do not understand the eligibility applications or simply do not wish to exert the effort. The linkage between ineligible individuals receiving services and individuals willfully defrauding the government is probably weak. However, given the complexity and the irrationality of the eligibility determination process, we would argue that the welfare system necessarily creates a large number of ineligible individuals who lack either the intent or the knowledge necessary to fradulently wheedle their way onto the rolls.

Further, we would argue that ineligibility is not the major eligibility issue. The major problem is reaching those citizens who qualify for certain services, who need those services, who have sought out the services but have been denied assistance because of administrative barriers. For

example, when New York first established Medicaid eligibility standards, 45 percent of the state's population became technically eligible for Title XIX benefits. Governor Rockefeller defended those standards on the basis that "experience showed that only 25 percent of persons actually eligible in fact signed up for public-assistance medical care programs."[59] Essentially, Rockefeller was endorsing a spurious standard. While he recognized the symbolic appeal of generous eligibility criteria, he was also aware of the fact that ignorance, social approbation and administrative red tape would pare down that eligible population to manageable proportions. We would suggest that that approach is fraudulent, that it violates Congressional intent, and that it requires bureaucratic complexities and ineptitude. Standards should not be set with the explicit objective of excluding a large portion of potential eligibles. If our goal is to reach all those who have a statutory entitlement to welfare benefits, the institution of a uniform eligibility process for all welfare programs would be a major step towards the attainment of that goal.

CHAPTER II

BENEFIT COVERAGE

A. Introduction

In the last few years, limitations on covered Medicaid benefits have been the most frequently employed of the cost control methods used by states. We shall examine here the application of benefit limitations as a cost containment mechanism. We shall analyze its potential effectiveness and its problems, attempting to draw some preliminary conclusions as to its relative weaknesses and strengths vis-a-vis other cost containment approaches. We shall argue that, in general, limitations on benefits will not be a wise or effective cost containment strategy. Benefit limitations will all too often (1) result in the substitution of other services, thereby limiting savings and, perhaps, increasing program expenditures; (2) create large administrative costs, relative the savings generated; (3) have undesirable effects on client health and welfare; or (4) shift costs to lower levels of government or to other federal or state programs.

Moreover, both eligibility and benefit coverage are so integral to the achievement of the Medicaid program's objectives that one can seriously question whether imposing limitations on either can contain expenditures without also changing objectives. The alteration of program objectives is obviously within the authority and political responsibility of state governments, but such actions are clearly of a different nature from those aimed at controlling costs.

The federal government requires that all Medicaid programs offer a

minimum benefit package consisting of physician services, inpatient and outpatient hospital care, laboratory and radiological services, skilled nursing care, home health care, Early Periodic Screening Diagnosis and Testing (EPSDT) for children and family planning services. In addition to these mandatory services, the states may provide the following array of optional services: (1) prescribed drugs; (2) intermediate care facility; (3) inpatient mental hospital; (4) clinic; (5) dental; (6) other practitioners, such as podiatrists, optometrists, psychologists, chiropractors and private duty nurses; and (7) other care, such as physical therapy, occupational therapy, prosthetic devices, medical supplies, dentures, corrective braces, hearing aids, emergency hospital care and transportation.

In 1974, mandatory benefits accounted for 64.4 percent of program costs nationally, as shown in Table I. Nearly 30 percent of Medicaid funds went for inpatient hospital care, while another 20 percent was expended on care in skilled nursing facilities. Seventeen percent of Medicaid funds were spent on physician services, with an additional 3 percent expended for outpatient services. Optional services represented 36.6 percent of Medicaid expenditures. Intermediate care facilities and pharmaceuticals represented, respectively, the most costly and the most extensively utilized of the optional services. Twenty percent of Medicaid expenditures supported care in intermediate care facilities for the mentally retarded and the chronically ill and care for patients in mental hospitals. Particularly in these cases, a substantial share of the costs

TABLE I

MEDICAID EXPENDITURES AND SERVICES
ALL AID CATEGORIES, 1974

	Mandatory Services			Optional Services			
	Expenditures (in thousands)	Percentage of Total Expenditures	Percentage of Mandatory Services		Expenditures (in thousands)	Percentage of Total Expeditures	Percentage of Optional Services
Total	$9,982,880						
Total Mandatory Services	6,421,216	64.4%	100.0%	Total Optional Services	$3,561,664	36.6%	100.0%
Inpatient Hospitalization	2,886,921	28.9	44.9%	Prescribed Drugs	712,562	7.1	20.0
Outpatient Hospitalization	322,010	3.2	5.0	ICF - Mentally Retarded	203,278	2.0	5.7
SNFs	2,001,861	20.1	31.2	ICF - Other Care	1,381,242	13.8	38.8
Physician	1,083,378	10.9	16.9	Inpatient Mental Hospital	405,917	4.1	11.4
Laboratory/X-ray	95,942	1.0	1.5	Dental Sources	264,567	2.7	7.4
Home Health Care	31,104	.3	.5	Clinic Services	284,293	2.8	8.0
				Other Practitioners Services	101,323	1.0	2.8
				Other Care	208,482	2.1	5.9

Source: U.S. Department of Health, Education and Welfare; Social and Rehabilitation Service, "Numbers of Recipients and Amounts of Payments". 1974 (Advance copy.)

reflects a state decision to shift services from existing state-funded programs to the Medicaid program. While such a shift did not necessarily increase the level or amount of services available to the states' citizens, it did increase the amount of federal funds available to the states. Prescription drug expenditures amounted to over $700 million or approximately 7 percent of program costs.

Recipients and expenditures per recipient for mandatory and optional services are shown for a geographically representative group of states in Tables II and III. Over 22 million individuals used Medicaid-financed services in 1974, with an average expenditure nationally of $453.58 per recipient. Physician services were used by 70 percent of all Medicaid beneficiaries, and average expenditures for these services amounted to $70.87, varying from $26.31 to $122.04 per recipient in the sample states. Medicaid financed some part of inpatient hospital care for over 3.3 million individuals, with average per capita expenditures of $859.46. Expenditures for residents of skilled nursing facilities have amounted to almost $3000 per person, ranging from $1878 per person in Texas to $4327 per person in Connecticut.

Medicaid is critical to the poor in financing prescription drug purchases. Nationally, expenditures averaged $49 for over 14.5 million recipients. Over 3.5 million individuals used dental services, with average expenditures ranging from $22.82 per recipient in Mississippi to $160.18 in Georgia. While relatively few individuals used other optional services, expenditures per recipient were quite high, reflecting the importance of those services to the users. For example, average expenditures

TABLE II

RECIPIENTS AND EXPENDITURES PER RECIPIENT FOR
MANDATORY SERVICES IN SELECTED STATES
ALL AID CATEGORIES, 1974

		Undup-licated Total	In-patient Hospital Care	Out-patient Hospital Services	Physicians' Services	Lab & Radiology Services	Skilled Nursing Homes	Home Health Service
Calif.	R *	3,712,759	469,506	1,086,271	2,685,344	1,775,188	153,541	12,149
	E/R	359.67	838.93	80.01	84.49	23.06	1987.19	125.28
Conn.	R	188,476	30,146	93,301	124,989	14,142	16,611	8
	E/R	710.29	924.95	71.80	71.57	27.09	4327.43	97.50
Ga.	R	454,397	80,163	173,493	346,258	17,347	23,234	853
	E/R	390.95	560.01	43.62	84.05	14.36	2462.51	204.39
Md.	R	404,931	63,517	216,017	294,038	18,101	7,297	1,939
	E/R	430.98	1081.73	86.07	54.13	12.47	3100.33	178.02
Mich.	R	903,928	170,333	314,646	621,921	52,652	34,755	2,433
	E/R	595.00	893.96	58.87	122.04	33.91	3743.10	204.87
Miss.	R	275,314	54,006	67,919	229,602	6,232	6,979	773
	E/R	276.87	341.83	24.74	62.11	16.84	2827.55	121.23
Montana	R	38,655	8,604	11,597	30,268	586	2,324	263
	E/R	514.75	503.13	37.35	93.01	14.56	2113.16	191.95
N.J.	R	572,327	80,834	249,982	422,076	71,885	16,275	1,920
	E/R	522.79	871.63	82.52	91.35	22.49	2881.24	257.59
Ohio	R	706,114	122,404	340,262	449,464	39,504	18,929	4,408
	E/R	425.58	775.14	60.80	78.42	20.28	2655.70	89.27
Pa.	R	1,531,475	217,905	680,550	1,449,835	218,500	65,280	42,770
	E/R	296.11	777.37	25.81	26.31	25.19	1985.42	37.50
Texas	R	685,538	150,584	209,427	567,152	309,145	13,516	425
	E/R	535.37	423.01	47.98	83.16	38.87	1877.65	72.40
Va.	R	293,218	37,397	120,139	197,395	67,820	1,196	1,275
	E/R	427.97	900.25	68.75	87.60	28.00	2373.82	301.71
Wash.	R	285,580	45,940	81,920	217,320	130,100	20,520	1,060
	E/R	465.68	714.49	49.95	78.30	31.97	2100.01	187.33
Wisc.	R	333,493	52,752	97,271	210,779	108,590	18,896	2,243
	E/R	730.75	722.03	54.51	83.63	21.44	3683.02	203.60
U.S.	R	22,008,607	3,359,024	676,165	15,255,952	5,699,185	4,170,507	150,264
	E/R	453.58	859.46	2,961.33	70.87	56.80	23.00	207.36

* R= Recipients

E/R = Expenditures per Recipient

Source: U.S. Department of Health, Education and Welfare; Social and Rehabilitation Service, "Numbers of Recipients and Amounts of Payments". 1974 (Advance copy.)

TABLE III

RECIPIENTS AND EXPENDITURES PER RECIPIENT FOR
OPTIONAL SERVICES IN SELECTED STATES
ALL AID CATEGORIES, 1974

		Prescribed Drugs	Dental Services	ICF Mentally Retarded	ICF for Others	Clinic Service	Other Practitioners Service	Mental Hospital	Other Care
California	R	2,527,816	736,056	0	26,369	42,080	616,468	11,540	290,582
	E/R	39.02	75.86	0	1,443.73	62.53	36.10	3,935.66	59.44
Connecticut	R	126,084	138,675	0	0	12,142	46,951	650	27,576
	E/R	57.05	53.01	0	0	104.26	38.57	5,092.85	88.68
Georgia	R	320,590	34,590	1,227	5,179	0	15,309	0	9,214
	E/R	54.61	160.18	2,466.33	2,194.63	0	41.76	0	40.06
Maryland	R	299,505	110,266	0	5,978	0	70,265	0	6,235
	E/R	52.16	89.36	0	3,321.73	0	32.38	0	79.95
Michigan	R	592,286	101,460	648	23,716	0	82,196	2,516	43,897
	E/R	59.01	109.00	7,248.95	3,041.46	0	77.27	11,046.79	40.68
Mississippi	R	232,389	36,274	1	1,548	0	644	0	31,067
	E/R	69.91	22.82	5,372.00	2,638.50	0	36.25	0	22.73
Montana	R	23,598	9,543	315	1,735	0	8,634	8,604	4,496
	E/R	47.59	91.00	1,893.28	1,813.76	0	57.83	36.43	172.36
New Jersey	R	432,266	142,263	0	15,769	26,385	83,316	8,007	95,685
	E/R	46.42	100.04	0	2,370.90	60.99	17.13	5,344.24	40.09
Ohio	R	500,149	165,831	0	17,626	19,813	133,675	569	52,749
	E/R	64.09	81.23	0	2,259.06	35.61	39.67	5,767.74	68.78
Pennsylvania	R	1,111,900	242,580	0	42,106	159,075	0	0	35,150
	E/R	26.50	35.54	0	1,116.52	39.84	0	0	6.36
Texas	R	500,422	0	12.78	65,867	0	757	1,453	87,444
	E/R	65.09	0	3,740.02	2,484.36	0	15.77	2,720.26	42.55
Virginia	R	212,366	27,234	2,427	9,612	40,257	25,263	569	54,135
	E/R	63.82	67.83	2,695.31	3,118.12	35.40	47.13	2,442.62	96.55
Washington	R	191,360	77,880	1,080	3,860	6,930	33,620	600	37,140
	E/R	53.53	112.71	1,265.43	1,279.70	150.14	34.82	4,231.20	41.00
Wisconsin	R	198,107	92,107	5,078	16,895	57,091	74,506	1,112	126,522
	E/R	59.47	74.26	7,074.49	2,115.60	93.65	86.69	2,150.87	45.99
Wyoming	R	0	1,356	0	810	0	0	0	54
	E/R	0	47.09	0	2,212.30	0	0	0	40.22
U.S.	R	14,543,488	3,579,172	40,008	604,146	2146,706	2,312,793	78,871	4,161,488
	E/R	49.00	73.92	5,081.95	2,286.82	132.41	43.81	5,138.19	50.10

*R=Recipients
E/R=Expenditures per Recipient

Source: U.S. Department of Health, Education and Welfare; Social and Rehabilitation Service, "Numbers of Recipients and Amounts of Payments". 1974 (Advance copy.)

were $207.36 for users of home health service, $43.81 for users of "other practitioners' service," and $50.10 for users of "other care." Substantial amounts were expended on the institutionalized mentally ill, the mentally retarded and the chronically dependent. Not all states provide coverage for individuals in mental hospitals or for the mentally retarded in intermediate care facilities. The states that do provide those benefits spend substantial amounts on relatively limited numbers of individuals.

Intermediate care facilities now provide institutional services for over 600,000 chronically dependent individuals, almost as great as the number using skilled nursing facilities. Although intermediate care facilities were designed as a lower-cost substitute for skilled nursing homes, it appears that they have acted only in part as a substitute, as both recipients of and expenditures for intermediate care have risen dramatically since that benefit was introduced in 1973. For example, between 1973 and 1975, Medicaid expenditures on intermediate care facilities increased at annual rates of 89.7 percent in Georgia, 92.5 percent in Iowa, 270.0 percent in Kentucky and 127.9 percent in Wisconsin, with only very small declines in the number of recipients of care in skilled nursing facilities.[1] Much of the increase reflects shifts from other state-supported living arrangements to Medicaid, representing, in part, decisions by states to support what are largely institutionalized housing and social services (with less emphasis on medical care) through the Medicaid program. While this increase contributes to the severity of the Medicaid program's problems, it is somewhat inappropriate to consider it part of the "crisis in health care."

TABLE IV

OPTIONAL SERVICE LIMITATIONS - 1975

Alabama	Eliminated inpatient psychiatric care for ages 21 and under
Arkansas	Limited prescriptions to three per month
Connecticut	Eliminated non-emergency dental care; optometry services and eyeglasses for over 21; chiropractors; private duty and practical nurse services
Florida	Eliminated prosthetic devices including dentures, eyeglasses, hearing aids and artificial limbs; optometrists' services, other practitioner's services and dental services; limit of $20 per month per recipient for drugs
Georgia	Eliminated adult dental and optical services
Louisiana	Eliminated coverage of non-prescription drugs except for insulin, calcium, iron and nicotinic acid
Maine	In-hospital private rooms and private duty nursing eliminated
Maryland	Eliminated dental care for adults over 21; supplies such as needles, syringes, insulin, family planning products; routine podiatry; custom foot supplies, disposable supplies, all durable convenience supplies; imposed limit of one pair of eyeglasses and one eye exam every two years for adults
Massachusetts	Eliminated clinic services; prescription drugs; dental care; prosthetic devices; eyeglasses for under 65; private duty nurses; physical, speech, and occupational therapies; optometric services; chiropractor services; audiological services
Michigan	Eliminated physical therapy in nursing homes, over-the-counter drugs, dental services for adults, vision and hearing services for adults, limited inpatient psychiatric care to 14 days per year
Nevada	Deleted intermediate care facility services for individuals 65 or older in institutions for tuberculosis
New Hampshire	Dental care for adults except for emergencies eliminated
New Jersey	Eliminated non-prescription drugs except for insulin and contraceptives, no replacement of lost or broken eyeglasses, adult dental services including dentures, optometry services, hearing aids, medical supplies, and psychological care
New York	Eliminated physical, occupational, speech therapies; audiology and x-ray services in non-clinical settings, chiropractor and podiatry services, over-the-counter drugs; private duty nursing; adult dental care
Virginia	Eliminated durable equipment and expendable medical supplies; prosthetic devices; all orthodontics; posterior endodontics and prosthetic devices for children
Texas	Eliminated coverage of psychiatric care for persons age 65 and over in mental hospitals; chiropractic services, eyeglasses, hearing aids, dentures, eliminated intermediate care facility coverage

Source: Medical Service Administration Memorandum, January 23, 1976 "Medical Cutbacks - October 1, 1975 through January 15, 1976".

TABLE V

MANDATORY SERVICE LIMITATIONS - 1975

Alabama	Reduced covered hospital days from 30 to 14 days, limited physician visits for those with chronic stable illnesses to one visit per month, limited inpatient hospital visits to one visit per day
Florida	Reduced covered hospital days from 45 to 30 days per year
Georgia	Limited inpatient hospital visits to one visit per day, limited physician office visits and hospital outpatient to one per month
Maryland	Will not pay for convalescent care in general hospital
New York	Twenty day maximum per illness
Tennessee	Coverage of certain therapeutic physician services eliminated
Texas	Reduced covered hospital days from 30 to 14 days
Virginia	Reduced covered hospital days to 14 days with up to 21 days with approval

Source: Medical Service Administration Memorandum, January 23, 1976 "Medicaid Cutbacks-October 1, 1975 through January 15, 1976.

For analytical purposes, we shall restrict our definition of benefit limitations to those mechanisms that affect all recipients and that limit the scope or nature of the services, the amount of services or the duration of services. As we have observed, the curtailment of benefits represents the most popular approach to Medicaid cost containment. For example, in 1975, six states limited inpatient hospitalization, two states cut back outpatient hospital services, three states curtailed physician services, and 15 states reduced their optional services (see Tables IV and V). The frequency and severity of these cuts in many dissimilar states does not indicate a commonality of health and welfare policy. Rather, it is a structural, programmatic response, guided by the relative ease with which benefits can be manipulated and by the belief that the program designations of "mandatory" and "optional" accurately reflect the medical necessity of Medicaid benefits.

The ability to implement rapid changes in Medicaid is constrained by a variety of factors: federal regulatory prohibitions; lengthy and complicated federal protocol; the need to arrive at a political consensus prior to program alterations; technical problems associated with changes in utilization controls, reimbursement procedures and financing schemes; and administrative resistance to complex changes. Of the major cost containment alternatives, benefits can be altered and restricted with the greatest ease. Further, there is a perception that such costs are inherently ordered; that is, that services listed as optional should be eliminated first and that restrictions of mandatory services should follow. In addition, legislators tend to believe that the curtailed

services interact minimally with the rest of the program. For example, in 1975, New Jersey and Florida eliminated prosthetic devices. These actions were based upon the implicit assumption that coverage of medical supplies as an optional service was of marginal importance and that all savings projected by closing the medical supplies account could actually be realized. In this particular case, most medical supplies serve as less expensive substitutes for costly hospital care or nursing home services. Because coverage of artificial limbs and braces has been eliminated, the Florida Medicaid recipient may be forced to consume more costly medical services.* Consequently, the projected savings may prove overly optimistic.

The confusion that arises as states alter their benefit packages originates with the way benefits were organized. Generally, a mandatory benefit package may be developed on the basis of medical, economic and/or political considerations. The medical criteria include delimitations of benefits according to the severity of the disability (identified specifically or in terms of the goods or services required to treat the disability); the inclusion of complimentary services (e.g., coverage for hospitalization which excludes laboratory and radiological services could

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*Individuals who require braces or artificial limbs typically have a critical need for them. Elimination of braces needed by young children can result in permanent physical deformity. Such deformity may ultimately inhibit these children from attaining their full potential for physical and psychological development. Delay in therapy until an older age is sometimes not possible and at other times undesirable. When delay is possible, the consequences will quite often be more costly forms of care. If children become permanent wards of the state because of a failure to provide braces, or if the unavailability of an artificial limb or braces produces a permanent resident in a long-term care institution, the state incurs expenses many times the cost of the prosthetic device. Parenthetically, prosthetic devices have not been isolated as examples of excessive or unnecessary service.

create medical delivery problems); and an appraisal of the medical technology and resource capacity of the health delivery system.

From a public perspective, economic considerations include an evaluation of an economic return on the health care investment in terms of future productivity or decreased dependency on community funds, the cost-effectiveness of the service, and the economic impact the service would have on the health care system. The investment in health services for children, for example, can be evaluated in terms of the future ability of those children to care for themselves and contribute to the community. Cost-effectiveness can be judged by the ability to finance a program, to purchase or provide services as inexpensively as possible and to allow for the benefit inclusion of low-cost substitute services. The system impact can be projected in terms of major price-and-supply responses to a new or expanded program.

Finally, benefits may be assigned because of political considerations that originate in the power of particular vested interest groups or in a deep sentiment of social and moral obligation. From that point on, historical precedent and the comparability of the benefits to other programs set the limits on benefit designation. The receptiveness of the providers becomes an important constraint, and the projected costs of the program vis-a-vis all other public programs becomes critical. If the cost is relatively small, the benefits may be determined solely upon political considerations. However, as projected and real costs spiral, medical and economic criteria become more relevant and topical.

The benefit package for Medicaid was determined primarily on political grounds. Since the program's costs were grossly underestimated, Congressional interest in or emphasis on economic or medical criteria was limited.[2]

Developed as an extension of the Kerr-Mills program, Medicaid was conceived as an income maintenance program designed "to help get people off the welfare rolls and generally to ease welfare budgets in the states."[3] The health aspect of Medicaid initially bore a striking similarity to Medicare; in general, those services mandated for Medicare were mandatory for Medicaid.*

While the Medicaid benefit package does bear considerable resemblance to the economic reality of medical care, it reflects the urgent needs of the non-impoverished elderly, rather than those of a welfare population. Several obvious Medicaid omissions support this contention. For example, pharmaceuticals are an integral, though relatively inexpensive, component of health care, but even comparatively small outlays for drugs may be too great for the poor. Nevertheless, drugs have been designated an optional service. The optional designation of prosthetic devices and medical supplies offers another example. Given that permanent and total disability is one precondition for Medicaid eligibility, it seems illogical that a medical precondition for aid is only optionally treated in a health program "designed" for the poor. A further peculiarity of Medicaid's benefit package is that the medically needy (a politically undefined population in 1965) are not "entitled" to any specific mandatory service. At a minimum, the states are required to provide only seven of all the services allowed under the Title XIX provisions.[4] Theoretically, a state could design a

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*Although, as the programs developed, their separate needs became important. Thus, a few years after enactment, Medicaid added home health care, EPSDT and family planning to its list of mandatory services.

medically needy benefit package which consisted of home health care, physical therapy, private duty nursing services, inpatient psychiatric care, prescribed drugs, dentures and hearing aids. While states with coverage of the medically needy have been much more comprehensive and generous than is technically required, it still remains a programmatic curiosity that certain medical services are mandatory (i.e., essential) for one group of the poor while they are not mandatory for another group. The medical or economic justification for the distinction becomes more strained once we identify the medically needy -- individuals impoverished because of illness and medical expenditures -- as the group not requiring a minimum level of mandatory services. The situation becomes sensible only in light of political criteria.

Finally, states have been permitted to offer a broad array of services. Initially, this listing allowed states which provided generous benefits to welfare recipients prior to Medicaid to continue to deliver the same level of services. Broad benefit coverage was also offered as a guide to expanding services, in order that the poor could eventually have unabridged access to mainstream medicine. The initial commitment to comprehensive care and mainstream medicine prohibited states from cutting back a service once it was incorporated into the program. Functionally, the states experienced a ratchet effect which froze them at current levels and encouraged only expansion. However, as Medicaid costs escalated vis-a-vis other public programs, and as states began to question the generosity of their medical benefits to welfare recipients vis-a-vis benefits in other health insurance plans, political pressure mounted. Congress responded through the 1972 Social Security Amendments that permitted states to retrench and cut back on benefits.

The major point is that mandatory and optional Medicaid benefits had been designed around political considerations. The recent cost containment efforts, on the other hand, presuppose some medical and economic rationale exists which support the benefit limitations. It is this rationale which we will examine.

B. Limiting Mandatory Services

Mandatory services account for approximately 64 percent of Medicaid's costs. However, pharmaceuticals and intermediate care facilities have, functionally, become mandatory services. Once these benefits are included, mandatory services represent 88 percent of Medicaid's costs. The functional distinction is important because states have followed a general pattern of limiting mandatory services and eliminating optional services; the distinction also serves to identify those services which must be limited if increases in costs are to be restricted. The optional services represent 12 percent of total costs. However, wholesale elimination of these services may not produce the desired results because (1) several of these services substitute for services which were previously financed totally by state and local governments, (2) several of the more expensive optional services are mandatory for EPSDT benefits (and therefore more cannot be eliminated), and (3) optional services act, in part, as lower-cost substitutes for more expensive mandatory services. In this section, we shall discuss the constraints and implications regarding the limitation of mandatory services; the following section will discuss the elimination of optional services.

Once a state has selected a benefit package, federal regulations require the following:

> A State Medicaid plan must specify the amount and/or duration of each item of medical and remedial care and services that will be provided to the categorically needy and to the medically needy, if the plan includes this latter group. Such items must be sufficient in amount, duration and scope to reasonably achieve their purpose. With respect to the required services for the categorically needy and the medically needy, the State may not arbitrarily deny or reduce the amount, duration, or scope of, such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition. Appropriate limits may be placed on services based on such criteria as medical necessity or those contained in utilization or medical review procedures.[6]

The minimum amount of goods or services is described only as that amount sufficient to "reasonably achieve their purpose." This standard is remarkably flexible. At one extreme, a state could provide all the medical services allowed under Title XIX; yet, it could be charged that its services were insufficient. On the other hand, some critics of the current practice of medicine have argued that most treatment is of such questionable efficacy that the large-scale provision of services does more to endanger the patient than help him. As one legal observer noted:

> This standard hardly provides any useful guidance. One must first determine the purpose of the category of the service, for instance physician services, and then determine whether a particular limitation would be so severe as to make the provision of that given service meaningless. Since some medical experts would argue that any limitations upon, for instance, a physician's judgment in rendering medical care, would make the provision of physician service meaningless, it is difficult to apply the regulatory standards.[7]

The end result is that the regulations fail to define benefits in terms of amount, duration or impact on the poor. Consequently, as guidelines, they are operationally undefinable. A standard which is undefinable is in fact no standard at all.

While the minimum amount of services is unspecified, the criteria for setting limitations is identified in negative terms only; that is, it may not include limitations on the basis of "diagnosis, type of illness or condition." Thus, targeting services by medical condition or severity of disability is prohibited. However, blanket restrictions on the duration or amount of services (15 days of hospitalization per year or 8 days per episode of illness) is not prohibited. Therefore, by federal standards, the six states which limit their hospitalization to 21 days or less per year are not distinguished from those with unlimited coverage; states which limit physician visits to one per month are indistinguishable from those with unlimited coverage, and so forth. Under such an arrangement, mandatory services can be constricted to the point that they are so meager as to be meaningless.

State action in this regard is not totally unfettered. The administrative guide to Title XIX, officially referred to as The Handbook of Public Assistance Administration, Supplement D, repeats the statutory directive that "limitations will not be set by eliminating certain groups of patients or certain diagnoses from coverage."[8] Further, it warns that "a token service which can only be ineffective on the one hand, and wasteful of funds on the other, will not be considered satisfactory. Institutional care should not be less in amount than would be required by most persons needing this kind of care."[9] Although they lack specificity, these regulations have allowed clients to successfully litigate against certain severe limitations. For example, in a case in Louisiana, clients

were able to prevent the state from imposing a limit of one physician's visit per month for all patients, including the chronically and acutely ill.[10] With the assistance of medical experts, the clients were able to demonstrate that the one visit per month was a token service which prevented the medical service from "reasonably achieving its purposes."

From the standpoint of the Medicaid recipient, this case exhibits two undesirable aspects of benefit limitations. First, remedial action by clients can be instigated only on an ad hoc basis. The vagueness of the definition of adequate duration or amount of services further requires that the limitations must be unquestionably severe. Second, benefit limitations are a non-exclusionary device; all must bear the hardships imposed by them. Unfortunately, they impose the greatest hardship on those with the most severe disabilities. This implication runs counter to the medical criteria for establishing benefits and the political considerations of an equitable distribution of benefits and hardships among a target population.[11]

From the perspective of the state, restrictions placed upon the most expensive benefits will give clients and providers an incentive to substitute less expensive Medicaid services as much as possible. If substitutes are inappropriate, insufficient or unavailable, the burden for providing the services will be shifted to the recipient (in terms of absorbing the cost or the negative medical outcomes which will follow if services are not provided), or to the local community, the county, or another state program. It should be stressed that the need for the service will not disappear and that someone must bear the burden. If the

state shifts to another state or local program, it may decrease its Medicaid expenditures, but it will forfeit the federal contribution and increase the financial burden on its citizens. These considerations become more concrete when applied to specific benefit limitations.

States have found that one of the few ways to contain hospital costs is to limit the number of covered benefit days.* The effects of such limitations are unclear at best. Those whose stays exceed 14 or 20 days are either seriously ill or those convalescing from surgery or other acute episodes. In many cases, the latter individuals can convalesce in a nursing home facility or at home at considerably less expense to the state. The seriously ill cannot. Thus, such a benefit limitation can be a very crude tool for achieving the cost control objective. (To avoid making arbitrary determination of need, Maryland eliminated coverage of convalescent care.)[12]

Limitations on hospital days can have serious effects on hospital budgets. For example, while less than 7 percent of Virginia's Medicaid patients had stays exceeding 14 days, expenditures on days beyond the fourteenth amounted to over 30 percent of hospital outlays.[13] The hospitals' response to limitations may not be desirable. Hospitals are not required to admit anyone needing care, but they are legally required to provide care to individuals once admitted.[14] This requirement places a legal limit on the ability of hospitals to avoid providing care to the seriously ill. To the extent that hospitals are not constrained by this

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*See chapters on Utilization Controls, Hospital Reimbursement and Cost Sharing.

requirement and that individuals are discharged sooner than would otherwise be advisable, there may be serious consequences for patient health.

A hospital's decision to continue to participate in Medicaid is strongly affected by the relative proportion of Medicaid patients it serves. Hospitals caring for a small volume of Medicaid patients may choose to drop out of the program or to absorb the cost of providing non-remunerated care to Medicaid patients. The ability of hospitals to absorb the added cost will depend upon the number of uncovered days, the percentage of non-Medicaid patients with other insurance and/or resources, the hospital's uncommitted reserves, its access to private philanthropy and its general financial conditions. If a hospital decides that its subsidization of Medicaid patients is unreasonable, and if its operation can be sustained by non-Medicaid patients, it will withdraw from the program. Large-volume Medicaid hospitals, however, do not have the option of withdrawing. If they cannot absorb the additional costs, they must either receive direct subsidies from the government, reduce the cost of their services (through increased efficiency or reduced quality of care) or cease to operate. As more private hospitals refuse to participate, the burden on public hospitals will increase. The cost of these increases in the use of public institutions is then shifted to local governments. Given the fiscal problems encountered by many of our major cities, such shifts could not only bear heavily upon the insufficient resources available to the cities but also increase reliance on far more regressive tax structures.

Additionally, a limit on hospital days would encourage transferral of Medicaid patients to skilled nursing facilities or intermediate care facilities. The decision to transfer would be a function of the patient's condition, the number of hospital days covered and the availability of beds in skilled and intermediate care facilities. Some transfers of patients may be quite rational; others may be medically inadvisable. In any case, outlays for skilled nursing or intermediate care will increase, partially negating the reduced hospital expenditures.

Limitations on physician visits are the next most common limitation on mandatory services. Several states have always had such limitations; others introduced them in 1975 in response to fiscal problems. Once again, such limitations as one visit per month are a crude tool for achieving the cost control objective. First, they are difficult and costly to implement. Second, individuals using more than one visit will consist of those with a serious physical injury or acute illness, those recovering from surgery, the chronically ill and hypochondriacs. While the latter are the appropriate target group, all will be affected. One likely consequence of restrictions on physician visits is an increase in the use of hospital outpatient services, unless these are similarly restricted. In many cases, services rendered in outpatient departments are more costly than similar services in physician's offices. The elimination of non-emergency outpatient hospital visits in Texas and limitations on those services in Florida are likely to result in the substitution of care by private physicians. The rate of substitution is dependent upon the availability of private physicians. If such care is not available, patients' medical status may deteriorate, requiring inpatient hospitalization.

Pharmaceuticals and care in intermediate care facilities have functionally become mandatory services or, more accurately, "mandatory-optional" services. With the exception of Oklahoma and Wyoming, all states provide for pharmaceuticals.[15] Intermediate care facilities are available in all states except Mississippi.[16] The reasons for their inclusion rest with medical and economic realities which were not critical considerations when Congress labeled these services optional.

Pharmaceuticals are an integral and complementary component of physician services, hospitalization, long-term care and other more expensive medical inputs. Their elimination can have costly repercussions. When suggested therapy is not supplied, costly diagnostic services can become ineffectual and wasteful. Without recommended pharmaceuticals, recipients may be forced to seek out more expensive forms of care. Consequently, rather than eliminate the coverage of drugs, the states have chosen to limit coverage. The implications of such actions are not clear. The exclusion of vitamin supplements, antacids, laxatives, cough suppressants and nasal decongestants, all pharmacologically active substances, can mean that patients either forego the purchase and endure whatever discomforts ensue or assume the cost of the drug. On the other hand, physicians can respond to these constraints by prescribing legend drugs which may be more expensive or risky than their over-the-counter substitutes.

Skilled nursing facilities (SNF) and intermediate care facilities (ICF) are services which are almost impervious to benefit limitations. For the most part, limitations on the use of nursing home care are most

effectively handled through (1) stringent utilization controls which restrict access, based on a variety of medical and/or social criteria and/or (2) limitations on bed supply, either directly (e.g., certificate of need) or indirectly (via reimbursement policy), both of which affect bed availability and thereby limit the number of individuals for whom the state will subsidize long-term institutional care. Such limitations can have enormous fiscal implications, as demonstrated in Tables II and III. The point to be made here is that benefit limitations are an inappropriate policy instrument.

Because the average stay in a nursing home is approximately two years, any limitation on the duration of SNF or ICF services will affect most of the patients and result in immediate, and extremely vocal, opposition from the nursing home industry, Medicaid recipients in the homes and the elderly in general.[17] The optional ICFs have become essential low-cost substitutes for SNFs and less expensive means of caring for the mentally retarded. In regard to the latter, the state can transfer patients from state institutions (funded entirely by state funds) to facilities supported by the federal government. In fiscal 1976, expenditures for the mentally retarded were increasing at a rate of 54 percent over the previous year:[18] the largest increase for any service, with exception of home health care.[19]

It should be noted, however, that ICFs may do more than substitute for other institutional services. To the extent that ICF care is not a substitute for SNF care, additional individuals with a chronic need for care are covered. The issue then becomes the desirability of subsidizing lower levels of care for the infirm and indigent. If the state wishes to

do so, it is clearly advantageous fiscally to provide care through Medicaid, even if federal standards, and thus unit costs, are higher than those which otherwise would have been acceptable to the state. On the other hand, the state may choose not to subsidize lower levels of care for the poor. If the mentally retarded ICF recipients could be supported directly by the state at less cost than the state share of expenditures under Medicaid, the state might consider eliminating Medicaid coverage of this service. In addition to the political opposition from the elderly, the poor and the industry, the elimination of ICFs would create considerable disruption for ICF residents. However, a compensatory response which might be expected is physician recertification of patients from ICFs to SNFs. The cost of increased SNF monitoring, as well as placement of the ICF population in suitable housing, might be politically unavoidable.

As a counterpoint to the "mandatory-optional" services of pharmaceuticals and ICFs, Early Periodic Screening Diagnosis and Testing (EPSDT) represents an "optional-mandatory" service which has met with state resistance. It is a service which has required federal cajoling and legal pressure; only within the past few years has it made substantive headway.[20] We shall not examine EPSDT services in detail because, unlike all other mandatory services, the states have actually assumed the responsibility for delivering the care required by EPSDT. Further, identification of EPSDT costs is difficult because the costs appear in different accounts (e.g., physician services accounts, dental accounts, etc.) and are therefore difficult to isolate. Finally, EPSDT services transform optional services, such as dental care, optometrist services and hearing aids, into mandatory services for recipients under 21 years of age.[21] Some

states, however, have been sufficiently irked by the imposition of the EPSDT program that they have considered not implementing the service and incurring the fiscal penalty of a 1 percent reduction in their AFDC welfare grants.[22] For example, a 1976 Ohio legislative budget office memorandum reported that "the Ohio Department of Public Welfare has been under a recent consent order to screen eligible children through EPSDT, and failure to do so will result in the imposition of fiscal sanctions against the state. Regardless of this potential loss of monies, the question of the need for EPSDT as a longer term means of reducing costs might be explored" (emphasis added).[23] HEW, of course, has greater potential leverage for enforcing compliance than the 1 percent penalty; it can deem the whole program out of compliance and withdraw all federal support. However, such an extreme response is unlikely because severe penalties are rarely enforced. Since the inception of the Medicaid program and throughout the more than 2,300 reported incidents of state non-compliance with federal regulations, not one state has had its federal share completely withheld.[24] Thus, states could, if they felt that EPSDT would cost more than the 1 percent penalty, quietly get "bogged down" in the implementation of EPSDT, suffer the sanction and, functionally, render a mandatory benefit optional.[25]

Careful consideration should be given to EPSDT regulations at the federal level. The EPSDT program clearly has the potential of becoming enormously expensive. Arguments for a massive screening program rest on the following kinds of assumptions: (1) that health problems of children

will not be detected through use of routine medical care services, (2) that, when health problems are uncovered through later diagnosis, they cannot be treated as effectively or as inexpensively and (3) that the value of early diagnosis and treatment, both in terms of medical expenses avoided and benefits to children (e.g., reduced discomfort, enhanced ability to learn) exceed the costs of universal screening. It is likely that these criteria will be met in some cases but not in others, suggesting that the program might be targeted much more carefully to specific age groups and to specific health problems. Changes in federal regulations would be helpful in assisting the states to contain current and future Medicaid costs.

C. Eliminating Optional Services

In 1975, 11 states acted to curtail the provision of 36 optional services:* 4 of these services were restricted; 32 were eliminated. The tendency to eliminate optional services may be explained in various ways. First, because each optional service represents a very small amount of Medicaid's total costs, the administrative expenses encountered in limiting the service might exceed the marginal savings accrued. However, even if savings could be realized, program managers have to weigh the relative returns in directing administrative resources to small expenditure accounts vis-a-vis the major cost areas of hospitals, nursing homes and physicians. The relative insignificance of the cost of optional services was demonstrated in Table I.

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*Because we have categorized pharmaceuticals as mandatory (or, more accurately, as "mandatory-optional"), we have not included the seven states which reduced their pharmaceutical services as a curtailment of optional services.

TABLE VI

OPTIONAL SERVICES, RECIPIENTS AND EXPENDITURES IN SELECTED STATES 1974
AID TO FAMILIES WITH DEPENDENT CHILDREN

		Other Prac. Services	Clinic Services	Prescribed Drugs	Other Care	In Mental Hospitals	ICF-Mentally Retarded	ICF-Others	Dental Services
California	Recipients	256,040	31,620	1,265,422	44,720	20	0	4,221	529,041
	Exp/Rec	36.05	43.03	13.82	62.06	560.15	0	1,330.29	69.51
Maryland	Recipients	36,702	0	194,133	742	0	0	7	83,014
	Exp/Rec	29.45	0	27.45	110.45	0	0	1,786.29	79.29
Connecticut	Recipients	28,518	3,301	92,151	15,004	47	0	0	34,156
	Exp/Rec	30.14	120.25	28.29	85.99	4,858.34	0	0	48.60
Georgia	Recipients	8,985	0	195,936	62	0	0	0	29,973
	Exp/Rec	56.01	0	23.4	121.77	0	0	0	149.59
Michigan	Recipients	64,117	0	456,527	28,755	1,481	67	14	96,549
	Exp/Rec	78.24	0	31.69	38.36	10,454.66	6,994.36	1,014.36	104.35
Mississippi	Recipients	27	0	127,383	26,881	0	0	3	28,239
	Exp/Rec	67.96	0	25.00	21.91	0	0	1,713.00	19.21
Montana	Recipients	5.924	0	14,980	1,367	5	55	11	7,880
	Exp/Rec	49.10	0	20.62	145.41	98.80	2,784.73	574.45	80.12
N. Jersey	Recipients	66,426	24,379	357,934	73,139	1	0	19	127,422
	Exp/Rec	16.75	55.51	33.20	30.39	14.00	0	1,195.79	95.07
Ohio	Recipients	98,692	16,818	380,072	23,701	0	0	6	147,154
	Exp/Rec	38.20	33.26	29.89	42.58	0	0	803.33	
Pennsylvania	Recipients	0	102,340	729,195	26,425	0	0	0	194,655
	Exp/Rec	0	31.94	16.36	6.32	0	0	0	33.77
Texas	Recipients	343	0	265,387	36,006	0	87	1	0
	Exp/Rec	15.94	0	27.35	52.61	0	3,555.66	140.00	0
Virginia	Recipients	14,680	35,539	142,094	34,776	0	937	69	27,115
	Exp/Rec	46.74	30.59	31.98	66.08	0	3,046.65	2,750.23	67.65
Washington	Recipients	20,000	3,320	107.700	14,800	0	0	0	54,140
	Exp/Rec	33.17	150.26	22.19	29.28	0	0	0	103.90
Wisconsin	Recipients	50,554	44,675	126,408	73,231	37	1,814	14	81,259
	Exp/Rec	58.62	93.01	26.44	25.27	1,930.89	8,605.31	734.07	72.70
Wyoming	Recipients	0	0	0	30	0	0	0	1,356
	Exp/Rec	0	0	0	47.27	0	0	0	47.09

Source: U.S. Department of Health, Education and Welfare; Social and Rehabilitation Service, "Numbers of Recipients and Amounts of Payments". 1974 (Advance copy.)

TABLE VII

OPTIONAL SERVICES, RECIPIENTS AND EXPENDITURES IN SELECTED STATES 1977
AID TO THE PERMANENTLY AND TOTALLY DISABLED

		Other Prac. Services	Clinic Services	Prescribed Drugs	Other Care	In Mental Hospitals	ICF-Mentally Retarded	ICF-Others	Dental Services
California	Recipients	125,574	6,860	482,202	69,317	9,660	0	11,862	93,034
	Exp/Rec	45.67	146.37	61.43	103.59	3967.82	0	1701.97	89.00
Maryland	Recipients	10,681	0	30,538	1,402	0	0	622	8,481
	Exp/Rec	41.16	0	113.90	122.86	0	0	5244.05	129.18
Connecticut	Recipients	6,240	1,209	13,513	5,790	20	0	0	2,928
	Exp/Rec	57.67	592.71	125.67	128.16	1698.90	0	0	90.11
Georgia	Recipients	229	0	34,986	312	0	1,186	2,038	1,893
	Exp/Rec	78,75	0	113.13	95.80	0	2477.23	2431.21	236.81
Michigan	Recipients	9,115	0	56,573	6,783	0	520	3,436	2,383
	Exp/Rec	94.53	0	147.73	58.92	484.00	7378.90	3445.19	246.21
Mississippi	Recipients	52	0	27,098	2,188	0	0	177	3,386
	Exp/Rec	80.27	0	132.90	33.48	0	0	2562.10	36.04
Montana	Recipients	1,436	0	3,692	1,540	87	259	390	1,153
	Exp/Rec	77.79	0	85.97	276.39	333.95	1672.56	2062.58	136.09
New Jersey	Recipients	6,218	864	23,395	9,013	2,946	0	1,676	5,789
	Exp/Rec	21.56	159.34	127.29	90.09	759.19	0	2,428.57	173.50
Ohio	Recipients	17,721	1,715	52,029	10,687	0	0	3,604	12,476
	Exp/Rec	50.94	62.91	160.72	141.88	0	0	2529.07	114.67
Pennsylvania	Recipients	0	13,950	90,760	4,365	0	0	13,429	10,795
	Exp/Rec	0	55.67	59.30	7.56	0	0	855.25	52.38
Texas	Recipients	69	0	31,829	5,003	0	1,083	5,729	0
	Exp/Rec	15.94	0	98.61	73.18	0	3764.46	2383.14	0
Virginia	Recipients	3,404	2,934	22,106	6,664	0	1,413	1,074	89
	Exp/Rec	53.17	85.62	132.41	180.95	0	2479.75	3454.97	122.26
Washington	Recipients	7,700	3,660	33,840	11,300	0	1,080	1,860	12,020
	Exp/Rec	42.41	150.04	99.91	50.15	0	1265.43	1266.97	139.84
Wisconsin	Recipients	7,142	4,264	19,101	13,398	21	2,189	3,790	5,362
	Exp/Rec	191.64	195.66	121.97	84.83	116.14	7745,80	2374.62	84.69
Wyoming	Recipients	0	0	0	6	0	0	126	0
	Exp/Rec	0	0	0	49.67	0	0	2000.89	0

Source: U.S. Department of Health, Education and Welfare; Social and Rehabilitation Service, "Numbers of Recipients and Amounts of Payments". 1974 (Advance copy.)

TABLE VIII

OPTIONAL SERVICES, RECIPIENTS AND EXPENDITURES IN SELECTED STATES, 1974
AGE OVER 65

		Other Prac. Services	Clinic Services	Prescribed Drugs	Other Care	In Mental Hospitals	ICF Mentally Retarded	ICF For Others	Dental Services
California	Recipients	209,203	1,070	667,676	165,646	1,280	0	9,639	72,565
	Exp/Rec	29.38	133.31	57.44	39.23	3,139.35	0	1,199.82	111.29
Connecticut	Recipients	12,091	7,591	20,155	6,665	583	0	0	1,519
	Exp/Rec	48.32	17.87	141.64	60.00	5,228.19	0	0	79.67
Georgia	Recipients	5,991	0	87,567	8,819	0	41	3,099	2,579
	Exp/Rec	19.05	0	100.33	37.60	0	2,151.02	2,035.56	214.71
Maryland	Recipients	12,277	0	37,366	3,424	0	0	5,334	6,052
	Exp/Rec	29.02	0	129.23	54.55	0	0	3,104.04	101.13
Michigan	Recipients	7,834	0	72,360	7,842	10	17	20,191	871
	Exp/Rec	52.13	0	163.65	32.12	291.70	6,762.35	2,973.41	245.80
Mississippi	Recipients	526	0	76,268	1,879	0	1	1,361	4,400
	Exp/Rec	27.38	0	121.99	21.15	0	5,372.00	2,650.18	35.35
Montana	Recipients	1,236	0	4,771	1,552	195	1	1,311	526
	Exp/Rec	76.78	0	100.87	96.42	1,456.08	27.00	1,756.12	153.09
New Jersey	Recipients	8,630	225	39,712	10,858	2,749	0	13,984	4,428
	Exp/Rec	16.55	115.61	117.05	60.39	12,587.74	0	2,308.63	166.75
Ohio	Recipients	16,683	1,191	65,586	17,824	569	0	13,832	5,662
	Exp/Rec	36.24	29.93	182.54	59.08	5,767.74	0	2,187.87	96.12
Pennsylvania	Recipients	0	5,735	96,505	0	0	0	28,452	4,600
	Exp/Rec	0	31.60	57.54	0	0	0	1,230.00	51.00
Texas	Recipients	340	0	200,342	45,924	1,453	107	59,857	0
	Exp/Rec	15.63	0	109.41	30.89	2,720.26	3,649.84	2,493.06	0
Virginia	Recipients	7,007	1,665	46,525	12,209	569	77	8,352	13
	Exp/Rec	45.00	48.60	126.85	136.33	2,442.62	2,375.55	3,075.34	100.23
Washington	Recipients	2,860	0	35,100	7,880	560	0	1,960	3,320
	Exp/Rec	25.03	0	116.40	52.99	4,390.95	0	1,290.74	155.90
Wisconsin	Recipients	16,585	7,980	51,815	39,315	1,054	874	13,035	5,249
	Exp/Rec	127.23	41.36	116.47	71.11	2,332.95	2,117.58	2,040.55	88.06
Wyoming	Recipients	0	0	0	18	0	0	678	0
	Exp/Rec	0	0	0	25.33	0	0	2,230.60	0

Source: U.S. Department of Health, Education and Welfare; Social and Rehabilitation Service, "Numbers of Recipients and Amounts of Payments". 1974 (Advance copy.)

The distribution of the cost for optional services in selected states is shown in Tables VI through VIII. The aid category breakdown indicates considerable differentials in cost and utilization patterns among AFDC, AD, and OAA. AFDC clients generally had the lowest average expenditures per optional service, with the exception of dental care--a mandatory EPSDT item for children. The elderly demonstrated more extensive and costly use of ICFs and pharmaceuticals, while the disabled recipient, on the average, had much higher expenditures in the catchall services of other practitioners (optometrists, chiropractors, podiatrists, private duty nursing, etc.) and other care (physical therapy, medical supplies, prosthetic devices, etc.). It should be noted that the inclusion of EPSDT overstates the optional component of these optional services. (As noted above, dental care, optometrists' services, hearing aids and other services labeled optional are mandatory for children covered by EPSDT, regardless of whether the state offers the services to the remaining eligible members of the population.) The resistance to imposing limitations on financially insignificant portions of the program has been noted by Wyoming's Medicaid director in his discussion of a limitation that his state imposed on its not-so-insignificant physician services:

> Several years ago we tried limiting the number of physician visits. Ours was based almost purely on a numeric limitation with extension of this limit only by request. We abandoned this for a couple of reasons. First, administratively it became a monster. Secondly, we were forcing physicians into a pre-judgment type of determination as to whether a patient needed additional care and thirdly, we were placing our limitations on what financially was the smallest part of our program. Our total expenditure for physicians service only amounted to 17% of our total budget and, thus, the minor reduction in cost there did not have enough effect on the total expenditure to warrant the administrative and provider relationship problems which this caused.[26]

Second, optional services are often considered to be of such marginal value that they can be eliminated without having any major negative impact on recipients. This sentiment reflects a belief that the federal categorization of optional services is based on the medical necessity of those services. What is overlooked is the arbitrary nature of any optional service designation; specifically, the political rationale for labeling services optional in the Medicaid program. When viewed in terms of a particular service, it becomes clear that some "optional" services are absolutely necessary for the client's health and welfare. For example, in what sense is insulin (a pharmaceutical) optional for a diabetic, or nitroglycerin optional for a patient recovering from a myocardial infarction? Is a wheelchair a luxury for a paraplegic, or the emergency room for a stab wound victim?

Finally, the elimination of optional services represents an immediate, visible and publicly understandable act which signifies an intent to "get serious" and gain control of an uncontrollable and complex program. Regardless of financial implications, the elimination of optional services allows program managers and legislators to present an image of aggressive fiscal management. This factor is perhaps the most compelling, particularly when large cost overruns are projected and action, any action, is viewed as essential.

In this context, we now present some general factors which deserve consideration as Medicaid programs undergo a contraction of services. We shall then elaborate on these factors as they relate to specific optional services.

Before a service is eliminated, program managers should examine the relationship of that service to other medical services, public services and funding sources. Any optional service may act as a substitute or complement for other services. For example, as noted previously, pharmaceuticals serve both as lower-cost substitutes for more intensive forms of care and as necessary therapeutic complements to other medical inputs. The elimination of pharmaceuticals would not only force substitution of more expensive services; it might render those services inadequate as well. In addition, an optional service may attend to needs not directly linked to the mandatory services; that is, it extends coverage to a population with certain unmet needs. Hearing aids for those with partial hearing defects is an example of such an add-on. When eliminating an optional service, consideration should be given to the degree to which substitutes are available (e.g., elimination of chiropractors may result in a large number of the recipients substituting physician services) and to the extent to which it complements other medical services (e.g., the elimination of prosthetic devices and medical supplies may have adverse effects on the usefulness and efficacy of certain types of surgery and physical therapy). Unfortunately, the ability to substitute one service for another has not been determined for many of the services under discussion. Informed speculation often becomes the only means for making this evaluation.

Optional services also tend to substitute for other public services (e.g., ICFs for public housing and care for the mentally retarded, occupational therapy for vocational rehabilitation programs, etc.). There

should be some attempt to trace the impact beyond the Medicaid program in terms of the costs of the alternative services and the funding of those services. In fact, if the state wishes to maintain its current total package of health-related services, while minimizing state and local tax burdens, it might attempt to cover as many services as possible under Medicaid and other federally sponsored programs. An evaluation could be made of federal-state programs which offer overlapping services (or the potential for overlapping services) at different percentage rates of federal financial participation. For example, State Vocational Rehabilitation Programs, Title XX and Medicaid allow a state, under certain conditions and for certain services, to select one of these programs as a funding source.[27] Since the federal share of total expenditures is 80 percent for vocational rehabilitation, 75 percent for Title XX and from 50 to 83 percent for Medicaid, there is a strong incentive for the states to maximize federal funds for specific services or minimize the impact of the elimination of a Medicaid benefit by transferring it to another program. Medicaid cutbacks which cannot be shifted to other federal-state programs will shift to the state, the locality, the provider and/or the Medicaid recipient.*

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*In response to Medicaid's shift to local communities, the National Association of Counties performed a survey of selected states on the financial role committees have played in Medicaid. Their conclusion was that, "the commitment of county governments to the Medicaid program is substantial. As health care costs increase, counties are being forced to rely on an already burdened property tax to support the health care of a small segment of their population. While dedicated to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandated service responsibilities to the burgeoning fiscal requirements of the Medicaid program. Cutbacks in services and/or eligible population provide no relief to counties, which are traditionally the providers of last resort. The effective response requires the federalization of Medicaid."[28]

In order to trace some of the implications of eliminating an optional service we briefly suggest possible repercussions for three of the services most frequently cut from Medicaid: dental care, optometry and podiatry.[29]

1. Dental Care

Dental care may be categorized by routine services, periodontics, endodontics, dentures and oral surgery. In the seven states which acted to eliminate dental services for adults, only Connecticut, Maryland and New Hampshire make an exception for emergencies. There has been a notable lack of attention to the distinctive types of dental care offered.

Ideally, dental care should be provided on a continuing basis, with periodic visits to dentists who can provide both preventive care, such as fluoride treatment, or restorative care for minor asymptomatic disorders, such as cavities, before the integrity of the teeth are threatened. In reality, many people do not use dental services preventively; care is usually sought when symptoms become evident. Care given to patients who are symptomatic is often very important; it can become essential if routine care is ignored. In the long run, remedial dental care is a worthwhile investment, because the presence of symptoms indicates an abnormality which, if left untreated, will lead to more serious disorders and more extensive dental care.

With regard to specific dental services, the value of periodontic care is controversial. Periodontic treatment is the scraping of infected tissues which secure the tooth to the gum. Since the presence of gum symptoms indicates chronic infection, treatment should be by medical rather than surgical means. It may therefore be appropriate to limit

periodontic care to medical rather than surgical therapy. This limitation would, in most cases, decrease the cost of care with little effect on outcome. Medical treatment could be provided by a general dentist.

Endodontic care refers to maintenance of a tooth which has been decayed to the point of internal but not external destruction. This care relates to root canal reconstruction and the elimination of infectious disease within the tooth. It is the most desirable manner of preserving a tooth, since the bite of the mouth remains the same. Failure to provide endodontic care can eventually lead to extraction and tooth replacement, requiring insertion of a bridge or, if most teeth are removed, dentures. Root canal work is expensive and time consuming, however, and thus more justifiably restricted than other kinds of dental care. Tooth removals, on the other hand, are a simple procedure and relatively inexpensive.

If endodontic care is eliminated, it may be necessary to maintain coverage of bridges and dentures. When a substantial number of teeth have been removed, it is desirable to retain tooth function for nutritional purposes, because the nutritive value of food increases with mastication. In the absence of mastication, an individual must either increase his food consumption or carefully alter his eating patterns to derive comparable nutritive value. Furthermore, because the absence of a substantial number of teeth can alter the physical appearance of individuals, significant psychological effects and, ultimately, physical health and welfare may be affected.

Another dental service frequently considered for restriction is oral surgery. Oral surgery is performed for major trauma to the face, such as a broken jaw, or for tumors of the gums and the base of the tongue. Orthopedists and maxilo-facial surgeons do similar work and may perform oral surgery if access to that service by dentists is eliminated. Services of physician surgeons are likely to be even more expensive than those of oral surgeons. Many surgeons, particularly the orthopedist, are not familiar with the process of restoring the bite of individuals suffering from a broken jaw. If a jaw is reset without consideration for bite, extensive dental work must be done subsequently to permit proper mastication, further adding to dental care expenses. In the absence of such work, there may again be changes in physical appearance as well as limitations on the functional state of the mouth--problems which are undesirable but not life-threatening. General dentists can perform minor oral surgery, such as biopsies, at a lower cost. Ear, nose and throat and maxilo-facial surgeons can do soft-tissue surgery. However, in many communities, maxilo-facial surgeons and oral surgeons are not widely available. Because so few people are specifically trained for care of these areas of the face, it would be unfortunate to prohibit the use of an oral surgeon when necessary. Net cost savings are likely to be small.

2. Podiatry

Podiatric services are provided to persons for both preventive and curative purposes. A proportion of the care that podiatrists give, particularly for structural disorders of the foot (as, for example, in a child with a foot or ankle deformity), can be substituted for by care

from more expensive orthopedic surgeons. Further, because orthopedists are not restricted to the use of medical therapy (prostheses, such as shoes and braces), they also treat patients through surgery which may ultimately prove far more expensive.

A major problem, however, has to do with the geographic distribution of podiatrists and orthopedists. Podiatrists are often available where orthopedists are not, or where orthopedists choose not to see Medicaid patients. In such a situation, the elimination of podiatry will decrease the availability of services. A loss of services is particularly critical in the treatment of the feet of persons with peripheral vascular disease and diabetes. For such persons, podiatrists provide necessary care to keep the patient's feet free of infection. Orthopedists' assistants, who can provide care, are not readily available throughout the country. The consequence of neglecting the feet for individuals with vascular problems is serious: the development of an infection which cannot be eliminated may lead to amputation, an expensive and permanently debilitating procedure. If podiatry services are limited, then, preventive care for persons with vascular disorders should be maintained. However, since regulations prohibit the structuring of benefits according to a recipient's medical condition, this step is impossible.

3. Optometry

Optometrists assess diseases of the external eye and of the lens and prescribe appropriate therapy, including lenses for refractive errors. These services can be provided by ophthalmologists at considerably greater cost. In many areas of the United States, ophthalmologists are few in

number; their services, therefore, are not readily available. In relative terms, there are 9.7 active optometrists per 100,000 population in urban states and 7.8 in rural states; there are only 4.8 active ophthalmologists per 100,000 in urban states and 3.6 in rural states.[30] Because of their relative scarcity and the consequent demand for their services, opthalmologists can refuse to see Medicaid patients, particularly when payment will be less than their usual fees. For those who need glasses but cannot see ophthalmologists, glasses are available in many states over the counter by a trial and error method. While such substitutes are better than nothing, they rarely correct refractive errors satisfactorily.

Certain similarities arise among all three of these optional benefits. If they are eliminated, there is the possibility of substituting services which, on a per-unit basis, are more expensive. Substitution may or may not increase total costs beyond the projected savings. It is certain, however, that some degree of substitution can be expected. Thus, the elimination of an optional service does not mean that the state will save all funds originally allotted for the service.

Further, before a benefit may be curtailed, all clients and providers must be informed in detail of forthcoming benefit cutbacks,[31] adequate provisions for hearings must be arranged, provider manuals must be altered, modifications in the claims invoice system must be made, and the claims review and editing systems must be changed. The administrative costs involved are not inconsequential. In some instances, the cost of the stamped envelopes necessary to inform recipients of impending cutbacks may cost more than the savings. For example, in 1974, Texas paid approximately

$12,000 for optometry and podiatry services.[32] If those services alone were eliminated, it would cost Texas more than $89,000 in postage to inform its 686,000 recipients of the change in the benefit package.[33]

Finally, dental care, optometry and podiatry services can be provided (under certain conditions) by Title XX, Vocational Rehabilitation programs, Maternal and Child Health Care programs, Developmental Disabilities programs, Comprehensive Employment and Training Act programs and a number of other programs. A review of all state health-related programs, their eligibility requirements and the potential for cross-subsidization of services offers an alternative to the elimination of these services.[34]

D. Conclusions

While we have not attempted to recommend the elimination of some services and the limitation of others, we have examined diverse implications of altering benefit packages. We began by suggesting that the most unfortunate consequence of federal constraints on benefit packages may be the implication of a logical priority of services. In states suffering severe fiscal strain, the temptation is to first eliminate optional services and then restrict "mandatory-optional" services (prescribed drugs and intermediate care facilities), "optional-mandatory" services (EPSDT) and "mandatory-mandatory" services. This approach assumes rationality in the federal designation of mandatory and optional. As we have seen, that designation fails to specify minimum levels of quantities of services, changes depending on the group under consideration, ignores the complementary nature of medical services as well as the state context within which the Medicaid program operates, imputes a marginal impact to optional benefits which

understates the critical nature of some of those benefits and, finally, assigns an implicit cost-saving potential to certain benefits which may in fact be spurious. In short, given the somewhat arbitrary, capricious and misleading designation of mandatory and optional, the justification for using that designation as the basis for a cost-containment strategy is not sound.

Beyond the two service categories of mandatory and optional, any attempt to limit benefits has several basic problems, primarily because benefits are applied to all eligible individuals regardless of medical status. Thus, those with the most severe disabilities are likely to suffer the greatest hardships when benefits are reduced. This situation raises questions about the efficiency and equity of benefit limitations. Because there is no clear understanding of how medical services interact as essential complements to and substitutes for other services, it is not evident that the elimination of certain services will result in saving money. In fact, it is plausible that a state may ultimately increase expenditures if some optional services are eliminated. Similarly, Medicaid benefits often serve as less expensive substitutes for comparable services funded entirely by the state or local area, e.g., care in mental hospitals and intermediate care facilities. Myopic concern with limiting Medicaid expenditures can lead to a greater state burden for those services. Also, because benefit limitations are subject to tight procedural requirements, failure to give adequate and detailed notice, or failure to provide hearings for recipients before cutbacks go into effect, can cause a program to be enjoined from putting the limitations into effect. Welfare rights organizations may schedule recipients for months of testimony, stalling the enactment of cutbacks and producing highly undesirable publicity.

Since benefit coverage and eligibility criteria are both integral to the goals and objectives of Medicaid, it can be argued that major curtailment of either is tantamount to changing the program goals and objectives. Since the program's objectives are politically determined, they should be altered if the political will and consensus demand a redefinition of the medical assistance program. However, if the goals are acceptable but the costs are not, there are other ways to control expenditures which are more equitable and efficient. Utilization controls permit greater targeting, allowing those clearly in need to receive services. Copayment mechanisms can be designed to bypass the inequitable characteristics of benefit limitations. The alteration of reimbursement policies may prevent excessive expenditures and discourage unnecessary services. Finally, changes in the federal/state financing mechanism might diminish the negative impact that recessions have on the states' welfare systems.

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7. 45 C.F.R. 248.1(c)(i).

8. 45 C.F.R. 248.1(c)(iv).

9. 45 C.F.R. 248.1(c)(v).

10. 45 C.F.R. 248.1(c)(vi).

11. 45 C.F.R. 248.1(c)(iii).

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14. 45 C.F.R. 248.1(b)(2)(v).

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19. 45 C.F.R. 248.1(c)(i).

20. 45 C.F.R. 248.1(c)(ii).

21. Joel F. Handler and Jane Hollingsworth, The "Deserving Poor" (Chicago, Illinois: Markham Press, 1971).

22. 45 C.F.R. 248.4(b)(4)(i).

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24. Urban Systems Research and Engineering, Inc. (USR&E), "Evaluation of Medicaid Spend-Down" (Cambridge, Massachusetts: February 15, 1976), p. vii. Prepared for the U.S. Department of Health, Education and Welfare, Social and Rehabilitation Services (Contract No. SRS 74-58).

25. For a discussion of the importance of the accounting period and procedures, see Jodie T. Allen, "Designing Income Maintenance Systems: The Income Accounting Problem," Issues In Welfare Administration: Implications of the Income Maintenance Experiments, Studies In Public Welfare. Paper No. 5 (Part 3), Congress of the United States, Joint Economic Committee, Subcommittee on Fiscal Policy, March 12, 1973, pp. 47-97.

26. 45 C.F.R. 248.10(b)(7).

27. Gail Sheilds, Lawrence Greenfield, Martin Abramowitz, "Termination of General Relief Cash and Medical Assistance to Employable Individuals: A Four Month Follow-Up Study" (Boston, Massachusetts: Massachusetts Department of Public Welfare, Office of Research and Planning, May, 1976), p. v.

28. U.S. Department of Health, Education and Welfare, Penalty Study: Quality Control and Management Improvement in AFDA, unpublished memo (Washington, D.C.: December 15, 1975); letter from James B. Caldwell, Commissioner of Social Security, to William J. Randall, Chairman, Select Committee on Aging, House of Representatives, January 19, 1976; James Dwight, "Bringing Better Management to Medicaid," The Social and Rehabilitation Record, Vol. 2, No. 4 (May 1975).

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54. Ibid., pp. 11 and 21.

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4. 45 CFR 249.10(a)(2)(ii)(A).

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7. Patricia Bulter, "The Medicaid Program: Current Statutory Requirements and Judicial Interpretations," Clearing House Review (May 1974), p. 12.

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9. Ibid.

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34. For a listing of programs which provide alternate funding services for similar services, see Utilization of Similar Benefits in Vocational Rehabilitation, Appendix A: Model Materials (Washington, D.C.: The Urban Institute).

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